



Isaacs, Anna (2018) Keeping healthy and accessing primary and preventive health services in Glasgow: the experiences of refugees and asylum seekers from Sub Saharan Africa. PhD thesis.

<http://theses.gla.ac.uk/8971/>

Copyright and moral rights for this work are retained by the author

A copy can be downloaded for personal non-commercial research or study, without prior permission or charge

This work cannot be reproduced or quoted extensively from without first obtaining permission in writing from the author

The content must not be changed in any way or sold commercially in any format or medium without the formal permission of the author

When referring to this work, full bibliographic details including the author, title, awarding institution and date of the thesis must be given

Enlighten:Theses
<http://theses.gla.ac.uk/>
theses@gla.ac.uk

Keeping healthy and accessing primary and preventive health services in Glasgow: the experiences of refugees and asylum seekers from Sub Saharan Africa

**Anna Isaacs
BSc, MSc**

**Submitted in fulfilment of the requirements
for the Degree of Doctor of Philosophy
Institute of Health and Wellbeing,
College of Medical and Veterinary Life Sciences,
University of Glasgow**

September 2017

Abstract

Background and aims:

Recent decades have seen material shifts in global migration flows. Migrants now come to the UK for an increasing number of reasons and from an increasing number of countries. This presents a challenge for health services that must provide care to individuals with a broad range of needs. In particular, there is concern that asylum seekers and refugees (ASRs) are at heightened risk of poor wellbeing and of receiving suboptimal healthcare.

Concurrent with these shifts in migration, increasing attention is being paid to non-communicable diseases (NCDs), which are now the most significant drivers of morbidity and mortality in most regions of the world. In the UK, the burden of NCDs is not evenly distributed, with inequalities related to ethnicity and socioeconomic status shaping an individual's risk of ill health. Little is known, however, about how diverse migrant groups, including ASRs, conceptualise health and respond to health prevention messaging.

Against this backdrop, this thesis aims to understand the health-related experiences of one such group – asylum seekers and refugees (ASRs) from Sub Saharan Africa living in Glasgow Scotland. Specifically, it explores: a) perceptions of health, wellbeing, and illness causation, b) experiences of accessing primary and preventive healthcare, and c) the factors influencing these perceptions and experiences. It also seeks to elucidate professional perspectives on ASR health.

Methods:

To gain an in depth understanding of ASR health perceptions and experiences, as well as professional perspectives, a focused ethnography was undertaken. This approach utilised four qualitative methods: community engagement, participatory focus groups, semi-structured interviews, and go-along interviews. In total 12 primary care and public health professionals were interviewed, and 27 ASRs took part in either a focus group, an interview, or both.

The thesis took a theoretically informed approach, seeking to determine whether and how two theories – ‘candidacy’ (Dixon-Woods et al 2005) and ‘structural vulnerability’ (Quesada et al 2011) – might deepen our understanding of ASR health.

Results:

Candidacy enhanced understanding of how ASRs identified and responded to messages about 'healthy lifestyles'. ASR participants considered keeping healthy to be an individual responsibility, with diet and exercise highlighted as especially important. At the same time, however, perceptions and experiences of health and wellbeing were shaped by a number of structural influences, which limited the capacity of ASRs to engage in health practices. Therefore, while ASRs considered health to be an individual choice in theory, they did not necessarily feel they had the ability to be healthy in practice.

The theory of structural vulnerability proved useful in identifying the wider structural determinants that impacted on an individual's capacity to respond. There were several important structural influences, including poverty, racism, discrimination, and language barriers. The greatest negative influence, however, and one that compounded all the others, was the asylum process. This diminished individuals' capacity to identify as candidates for prevention messages, engage in preventive health practices, and/ or access care in an optimal fashion.

Conclusions:

Efforts to engage ASRs in preventive health programmes and practices must take into account the ways in which the immigration and asylum system acts as a determinant of health, affecting both what it means to be healthy and what capacity individuals have to engage. The NHS, together with non-statutory bodies, has a role to play in mitigating some of the vulnerabilities to which ASRs are subject.

Table of Contents

Abstract	2
List of Tables	8
List of Figures	9
Preface	10
Acknowledgements	12
Author’s Declaration	13
Abbreviations	14
Definitions	15
Chapter One: Introduction	17
1.1 Refugees and asylum seekers in the UK	21
1.1.1 Refugees, asylum seekers and ethnic minorities in Glasgow.....	22
1.2 The Scottish policy context	24
1.3 Problematising key terms: culture, ethnicity, and race	25
1.3.1 Culture	25
1.3.2 Race and ethnicity	27
1.4 Aims and research questions	29
1.5 Format of the thesis	30
Chapter Two: Literature review: health, prevention, and access to healthcare	33
2.1 Scope of review and search strategy	34
2.2 Broad trends in migrant health research	35
2.2.1 Migrant health vs. ethnicity and health	36
2.2.2 Divisions between migrant and ethnic minority health and health inequalities research	37
2.2.3 Concerns around data and definitions	37
2.2.4 Culture and cultural competence.....	39
2.3 Access to primary and preventive care	40
2.3.1 Access to primary care	41
2.3.2 Factors impacting on healthcare use	42
2.3.3 Problematising entitlement.....	47
2.3.4 Focus on preventive care.....	49
2.3.4.1 What makes a targeted intervention?	50
2.3.5 Culture and health	51
2.3.6 Language	55
2.3.7 Non-health priorities	56
2.3.8 Professional perceptions.....	56
2.4 Situating ASRs from Sub Saharan African in Glasgow	58
2.4.1 ASR health and wellbeing in the UK.....	58
2.4.2 Statutory responses to refugees and asylum seekers.....	59
2.4.2.1 Access to primary care	60
2.4.3 Sub Saharan Africans in Glasgow.....	61
2.5 Conclusion	63
Chapter Three: Theoretical perspectives	65
3.1 Alternative theories	66
3.1.2 The Patient Centred Access to Care conceptual framework	66
3.1.3 Syndemics theory	66
3.2 Candidacy	67

3.2.1 The construction of candidacy	70
3.2.2 Utility of candidacy as a framework	71
3.2.3 Candidacy and prevention	72
3.2.4 Critiques of candidacy	73
3.2.5 Moving toward a critical perspective	75
3.3 Structural vulnerability	75
3.3.1 Origins of structural vulnerability	76
3.3.2 Theorising structural vulnerability	78
3.3.3 Unpacking perceptions	79
3.3.4 Integrating the individual with the structural	80
3.3.5 Moving beyond social determinants of health	81
3.4 Constructing a comprehensive analytical lens	83
3.4.1 Breadth and depth	84
3.4.2 Bridging structure and agency	86
3.5 Conclusion	86
Chapter Four: Methodology	88
4.1 Methodological Perspectives	88
4.1.1 Developing a disciplinary orientation	88
4.1.2 Positivism, social constructivism and critical realism	90
4.1.3 Rigour in qualitative methods and analysis	92
4.1.4 Reflexivity & power in the research process	93
4.2 Research design	95
4.2.1 Ethnography	95
4.2.1.1 Focused ethnography	96
4.3 Research design and development	99
4.3.1 Field site	99
4.3.2 Sampling and recruitment	100
4.3.3 Ethical approval	101
4.3.4 Conducting the focused ethnography	103
4.3.4.1 PHASE 1: Community engagement	103
4.3.4.2 PHASE 2: Participatory mind-mapping	105
4.3.4.3 PHASE 3: Interviews	108
4.4 Analysis	112
4.4.1 Data organisation	113
4.4.2 Data analysis	113
4.5 Research Questions	114
Chapter Five: Introduction to the results	115
5.1 Layout of the results	115
5.2 The field site(s)	116
5.3 The participants	117
5.4 Participant stories	119
5.5 The all-pervasive experience of being a migrant	121
Chapter Six: Narratives of health and wellbeing	124
6.1 What is health, and what keeps people healthy?	125
6.1.1 Biological basis of health and illness	126
6.1.2 Role of ‘behaviour’	129
6.1.3 The body as an indicator of health or illness	132
6.1.4 Health as dependent on emotional wellbeing	134
6.1.5 Health as influenced by the environment	137
6.2 Perceptions of, and engagement with, health practices	138

6.2.1 Diet	138
6.2.2 Exercise	146
6.2.2.1 Access to exercise.....	147
6.2.2.2 What facilitates exercise?	149
6.2.3 Cleanliness	152
6.3 Perceptions of NCD risk, primary prevention and preventive care	153
6.3.1 Perceptions of NCD risk	153
6.3.2 Access to preventive services	157
6.4 Conclusions	160
Chapter Seven: Access to services	161
7.1 Access to primary care	161
7.1.1 Cultural differences in the production of candidacy	163
7.1.2 Physical access to services	167
7.1.3 Experiences of engagement with professionals	172
7.1.4 Interpreting	174
7.2 Access to social support	178
7.2.1 Role of community organisations	179
7.2.2 Role of volunteering.....	180
7.2.3 Navigating support	181
7.3 Conclusion	183
Chapter Eight: Determinants of refugee and asylum seeker health	185
8.1 Impact of the asylum system	186
8.1.1 The asylum process as all consuming	187
8.1.2 Uncertainty	189
8.1.3 Dehumanisation and lack of agency.....	190
8.1.4 Intersection with place	194
8.1.5 The health impacts of destitution	196
8.2 The political/ media context around asylum and migration	198
8.3 Racism, discrimination, and ‘othering’	200
8.3.1 Perceptions of racism in Scotland	201
8.3.2 Implications for wellbeing	202
8.3.3 Implications for service use.....	204
8.3.4 Being ‘other’ and using space	205
8.4 Access to financial resources	206
8.4.1 Impact of financial constraints on health practices	208
8.4.2 Professional responses.....	211
8.5 The neighbourhood environment	212
8.5.1 Neighbourhood facilities	213
8.5.2 Concerns around anti-social behaviour	214
8.5.3 Participant geographies	215
8.6 Conclusion	217
Chapter Nine: Discussion	219
9.1 Research questions	219
9.2 Developing the Candidacy framework.....	223
9.2.1 Extending candidacy to prevention	223
9.2.2 Using the theory of structural vulnerability to enhance understanding of candidacy.....	224
9.2.2.1 Identification.....	225
9.2.2.2 Navigation and permeability	226
9.2.2.3 Presentation, adjudication, and offers and resistance	227
9.2.2.4 Operating conditions and local production of candidacy	227

9.3 The asylum system as a determinant of health	230
9.4 Reflections on research with marginalised groups	232
9.4.1. Recruitment challenges	233
9.4.2 Interpreted interviews and establishing rapport	233
9.4.3 Questioning formal ethics procedures.....	234
9.4.4 Ethics in practice: meeting expectations	236
9.4.5 Ethics in practice: paying participants	237
9.5 Strengths and limitations	237
9.6 Research implications and recommendations	239
9.6.1 Implications for UK asylum policy.....	239
9.6.2 Implications for Scottish integration policy	239
9.6.3 Implications for the NHS	240
9.6.4 Implications for primary care practice	241
9.6.5 Further research questions.....	242
9.7 Conclusion	243
Appendix A: MVLS ethics approval.....	245
Appendix B: NHS GG&C R&D approval.....	246
Appendix C: NHS GG&C letter of access	248
Appendix D: Recruitment Poster	250
Appendix E: Interview invitation letters	251
Appendix F: Participant information sheets	256
Appendix G: Consent form – Ketso, ASR, public health, primary care interviews..	274
Appendix H: Topic guides.....	276
Appendix I: ASR data collection form.....	284
Appendix J: Literature review search terms.....	286
Appendix K: Ketso session data	287
Appendix L: Coding Framework	290
Appendix M: Example OSOP.....	293
List of References	294

List of Tables

Table 1: Barriers to accessing care for migrants adapted from O'Donnell et al 2016.....	44
Table 2: Best practice for targeted interventions from Netto 2012:262-265	50
Table 3: Description of each stage of candidacy	70
Table 4: Examples of focused ethnographies in health research	98
Table 5: Interview numbers by type	100
Table 6: Explanation of Ketso leaves	106
Table 7: Participants in each Ketso session	107
Table 8: ASR participant demographics	118

List of Figures

Figure 1: candidacy model as illustrated in Mackenzie et al 2013	69
Figure 2: features of a focused ethnography	97
Figure 3: components of focused ethnography	99
Figure 4: fieldwork timeline	103
Figure 5: a KETSO board in progress.....	108
Figure 6: recap of the candidacy framework	125
Figure 7: modified candidacy framework.....	230

Preface

“We are strangers here and you have your own lifestyle so we are barging into your way of life” – Brenda (f, 50-59, Malawi, asylum seeker)

Over the four years that I have researched and written this PhD thesis (2013-17) there has been much political upheaval, both in the UK and internationally. This has had a direct impact on refugees and asylum seekers, but has also been felt far more broadly. It would be remiss to begin this thesis without commenting on the many events that have influenced the topics contained herein.

The environment for migrants in the UK over this period has not been an accommodating one. During the 2015 UK general election campaign both the government and opposition vied to demonstrate a tough stance on immigration. The coalition government hardened its rhetoric on migrants (e.g. through ‘Go Home’ banners displayed on vans), while the Labour Party made immigration control one of its key manifesto pledges. The 2016 EU referendum once again brought this to the fore, with immigration a key factor in the ‘Vote Leave’ campaign. During this time, undercurrents of racism and xenophobia became overt, evidenced by the devastating murder of Jo Cox MP just prior to the referendum, and a rise in racist attacks in the UK immediately following it. In 2017, as the terms of Brexit are being negotiated, it is still unclear what the implications will be for EU migrants.

Concurrently, 2015 saw the refugee crisis enter the public consciousness and become a constant feature of front page news. Largely fuelled by the war in Syria, record numbers of individuals have sought to reach European shores, embarking on perilous journeys, many of which have ended in tragedy. While the numbers of asylum seekers arriving in the UK have not increased materially, concern about this issue has been widespread. There have been expressions of both support and opposition, with the tabloid press stoking areas of disagreement among an increasingly polarised public.

Regarding the health inequalities agenda, the publication of the Marmot report, ‘Fair Society, Healthy Lives’ in 2010, followed by the WHO report from the Commission on the Social Determinants of Health in 2015 have brought concerns around unequal health outcomes into the mainstream. At the same time, the entrenchment of austerity policies following the 2015 UK general election has led to deep cuts to public health, to social care

and to a plethora of frontline services that provide support to asylum seekers, refugees, and other marginalised populations.

The research on which this thesis is based therefore touches on many of the most salient political and social issues of the decade – immigration, race, responsibilities towards asylum seekers and refugees, access to healthcare, health inequalities, and public health provision at a time of austerity.

Acknowledgements

While writing a PhD thesis might be a solitary pursuit, it is not one that that can be completed alone.

First, I owe a huge debt of gratitude to the participants in the study who told me their stories with patience and generosity. The thesis would not exist without them, and I hope I have done them justice. Secondly, the stakeholders at the community organisations I engaged with went beyond the call of duty to assist me with recruitment and facilitation of focus groups.

My PhD supervisors, Kate O'Donnell, Nicola Burns, and Sara Macdonald have not only provided me with invaluable advice and support, but also a great deal of laughter during supervisions over the past four years. I am also grateful to Danny Wight and Chris Bunn for providing me with excellent food for thought during challenging annual reviews.

I have been extremely lucky to be based in the supportive environment of General Practice and Primary Care, where I felt as much a part of the department, as a PhD student, as any other member of staff. In particular, I would like to thank Michelle McKelvie and Michere Beaumont for their support with administration and transcription, and my colleagues (and now friends) in Room 202, Karen Wood, Kathryn Saunderson, and Ross McQueenie for making it such an enjoyable place to work.

Writing a PhD can be an isolating experience and in this regard I have been fortunate to have a number of fellow PhD buddies with whom to work alongside. Marion Boulicault, Clementine Hill O'Connor, Mary Anne Macleod, Alexia Sawyer, and Hannah Walters all accompanied me on this PhD journey during writing retreats in Skye, Kent, London, and Glasgow.

Lastly I would like to thank my parents for their unending support and incredible proof-reading skills, and Ben, for far more than I have space to write here.

Author's Declaration

I declare that, except where explicit reference is made to the contribution of others, that this dissertation is the result of my own work and has not been submitted for any other degree at the University of Glasgow or any other institution

Signed:

Printed name: Anna Isaacs

Abbreviations

ASR – Asylum seeker and Refugee

CVD – Cardiovascular Disease

NHS – National Health Service

NHS GGC – NHS Greater Glasgow and Clyde

OSOP – one sheet on a page analysis

SSA – Sub Saharan Africa

T2DM – Type 2 Diabetes Mellitus

UKBA – UK Border Agency

UNHCR – United Nations High Commission for Refugees

Definitions

Asylum seeker:

The Refugee Council defines an asylum seeker as: ‘A person who has left their country of origin and formally applied for asylum in another country but whose application has not yet been concluded’ (refugeecouncil.org.uk). Asylum seekers apply for protection under the terms of the UNCHR Refugee Convention, or article 3 of the ECHR. Asylum seekers waiting for a decision on their claim are not allowed to work. They receive an allowance of £36.95 a week and are provided with accommodation (<https://www.gov.uk/asylum-support/what-youll-get>).

Refused asylum seeker:

A refused asylum seeker is someone who has had their claim for protection in the UK refused.

Many refused asylum seekers have all support cut off and either become destitute, are forcibly removed from the country, or are put in detention. Some are granted ‘Section 4’ support, which provides accommodation and a £35.94 provided on a cash card (https://www.refugeecouncil.org.uk/policy_research/the_truth_about_asylum/the_facts_about_asylum).

Refugee:

The 1951 UN Refugee convention defines a refugee as someone, who, ‘owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion, is outside the country of his nationality, and is unable to or, owing to such fear, is unwilling to avail himself of the protection of that country...’

Asylum seekers whose claims are considered to be consistent with terms of the convention are granted refugee status in the UK, which affords them leave to remain for five years. At the end of the five years they are eligible to apply for permanent leave to remain, though their status can be revoked if their home country is considered safe to return to

(https://www.refugeecouncil.org.uk/policy_research/the_truth_about_asylum/the_facts_about_asylum).

Migrant:

Migrant is used as a general term to describe someone who is residing in a country other than that in which they were born.

Immigrant¹:

In the US the term immigrant is often used instead of migrant to describe someone who is residing in another country other than that in which they live.

Undocumented migrant

Undocumented migrants are those who are not legally authorised to be in the country in which they are residing. Individuals may become undocumented after a visa runs out, having had their asylum application rejected, or if they enter the country irregularly (picum.org/en/our-work/who-are-undocumented-migrants)

Primary prevention:

Primary prevention involves efforts to reduce rates of disease across a population through interventions that address lifestyle risk factors and the circumstances that cause them. Primary prevention can target either an entire population, or particular ‘at-risk’ groups (<https://www.kingsfund.org.uk/projects/gp-commissioning/ten-priorities-for-commissioners/primary-prevention>).

Secondary prevention:

Secondary prevention involves efforts to intervene at an early stage in a disease in order to reduce morbidity and mortality (e.g., prescribing statins to lower cholesterol and reduce CVD risk) (<https://www.kingsfund.org.uk/projects/gp-commissioning/ten-priorities-for-commissioners/secondary-prevention>).

¹ This thesis refers to both migrants and immigrants, depending on what is used in the literature being referenced.

Chapter One: Introduction

This thesis deploys ethnographic methods to examine the health and healthcare experiences of one migrant group in the UK – asylum seekers and refugees (ASRs) from Sub Saharan Africa (SSA) living in Glasgow, Scotland. It is interdisciplinary in nature, drawing on tools from the fields of primary care and critical medical anthropology. Principally the thesis aims to understand: i) what being healthy and well means to ASRs, ii) perceptions of non communicable disease (NCD) risk and prevention, and iii) experiences of engagement with primary and preventive care. Rather than focusing solely at the individual level, I aim to explore how structural factors, in particular the strains imposed by immigration status, shape ASR health in Glasgow. This is especially important as Castañeda et al note that a social determinants lens is rarely used to examine immigrant health, which in turn hampers public health's capacity to develop successful interventions (Castañeda et al 2015)².

Over the past century migration flows around the world have increased in complexity, with large numbers of people from a wide range of countries making their home somewhere other than where they were born. In the UK, the increase in diversity of migrant groups has led to the development of the concept of 'superdiversity' (Vertovec 2007) which describes the qualitative and quantitative shifts in the country's migratory patterns. Individuals come to the UK for a plethora of reasons and contribute enormously to the country's economic and cultural wealth. At the same time, a commitment is required, on the part of public and voluntary services in the UK, to respond to and integrate an increasingly broad range of needs (Jayaweera 2010:1; Rechel et al 2011a:3). Issues facing health and healthcare provision include responding to physical and mental health needs as a result of migration, training a culturally competent workforce, ensuring equitable access to care, accommodating different perceptions in health and wellbeing, and addressing ethnic inequalities in health. While there is a 'healthy migrant' effect for some, there is evidence to suggest that certain migrant groups, in particular asylum seekers, refugees, and undocumented migrants, suffer considerable health inequalities in terms of both physical and mental health conditions (Ingleby 2012b; Warfa et al 2006:503), and that migration-related experiences may also intersect with other factors (e.g., socioeconomic status, gender) to compound this inequality (Nazroo 2003).

² Where I am referring to a whole paper I note only the year, but where I am referring to a specific point I also provide the page number.

Concurrent with changes in migration flows is the epidemiological transition (McKeown 2009) whereby NCDs have surpassed infectious disease as the most significant cause of mortality in most regions of the world (Global Burden of Disease 2015). Cardiovascular disease (CVD) is the biggest cause of death worldwide (WHO 2013), and Type II diabetes mellitus (T2DM) which has very similar risk factors (and is itself a CVD risk factor) is also increasingly prevalent (diabetes.co.uk; Global Burden of Disease Risk Factors Collaborators 2015). Although in low and middle income countries public health efforts are still predominantly focused on infectious diseases, concern about the sharp rise in NCDs and their associated risk factors is increasing as well (Global Burden of Disease Risk Factors Collaborators 2015).

In the UK, as in other high income countries around the world, the burden of NCDs is not evenly spread across the population, with a large body of evidence demonstrating the strong links between socioeconomic status, ethnicity, and rates of NCDs, such as CVD (Beauchamp et al 2010; Gill et al 2007; Lip et al 2007). Indeed, there is a rich history of research in the UK that has drawn links between social and economic status and health outcomes, with notable early contributions including the Whitehall Studies, the Black Report in 1980, and the UK Independent Enquiry on Inequalities in Health (the Acheson Report) in 1998 (Birch 1999; Marmot et al 1991).

Not only do those at the lower end of the socioeconomic spectrum experience far higher rates of chronic disease and chronic disease risk factors, but there is evidence that this is also the case for certain migrant and ethnic minority groups independent of their socioeconomic status (Agyemang et al 2011:563). A prime and oft-cited example is the high rates of cardiovascular disease amongst people of South Asian origin (e.g., Bhopal 2011). While genetic variation by ethnicity may partly explain these health outcomes, many of the reasons for disparities can be attributed to the social determinants of health, as well as poorer and less satisfactory access to healthcare among certain sectors of the population (Kallayova & Maidan 2012:287).

The burden of NCDs has led to concerted efforts in the UK, and elsewhere, not just to develop novel methods of treatment, but also to address NCD risk factors, so that disease may be prevented in the first place (WHO 2014b). The opportunity to modify risk factors and prevent NCDs is significant, given the high costs related to both treatment, and to loss of productivity due to illness. In high income countries, population aging, multimorbidity, and the increasing costs of health and social care make the need for effective preventive

strategies even greater. This need has resulted in a proliferation of preventive interventions. These interventions (targeting both primary and secondary prevention³) tend to be based around notions of individual behaviour change (Castañeda et al 2015:378), although there is still limited evidence about what types of health promotion interventions are the most effective in migrant populations (Netto 2012:257). Interventions also carry with them the inherent risk that they will actually serve to increase inequalities in health outcomes, since those who have the resources to engage with them are able to benefit, whilst individuals who do not have those resources do not see similar benefits (Beauchamp et al 2010; Mackenzie et al 2011; White et al 2009). This risk is magnified when interventions rely primarily on individual behaviours, and fail to take into account the social, political, economic, cultural, and historic contexts which shape those behaviours and an individual's exposure to risk (Baum 2010; Krieger 2008; Raphael & Bryant 2015).

There is limited knowledge about perceptions of NCD risk and prevention amongst migrants in the UK, though it is known that migrants in general make less use of preventive services, and greater use of emergency services than the rest of the population (Graetz et al 2017:12-13; Norredam & Krasnik 2011:69). At the same time, most epidemiological research on NCD risk factors has been conducted with white rather than minority populations (Brindle et al 2006:1595; Lip et al 2007:185) and so it is unclear what preventive measures might work best with a given population (Homji et al 2011:1). Cooper et al (2012) used Kleinman's 'explanatory models' to explore Glasgow resident French- and Swahili- speaking African migrants' perceptions of NCD risk. They noted that only those participants who already had an NCD considered themselves to be at risk, while other participants focused mostly on infectious diseases (Cooper et al 2012:603). When asked about NCD causation, they referenced inheritance, stress, dietary imbalances, and the toxic nature of 'western' food as primary risk factors (ibid:608). Overall awareness was low and the role of obesity as a risk factor was little considered (ibid). This led to a recommendation that health promotion interventions be built around lay models of risk perception. However, although most of the participants in Cooper et al's study were ASRs, the paper did not engage with the contextual factors that might have shaped risk perception or engagement with health practices and there is a need to interrogate notions of health and risk, in relation to migratory experiences.

³ See list of definitions for definitions of primary and secondary prevention

Sub Saharan Africa is a vast region, comprised of individuals from a large number of countries, with different cultural, linguistic, social and economic backgrounds. It is an important premise of this thesis that there is no assumed homogeneity in the background, experience, or perceptions of SSA migrants. That said, there is a small body of evidence (discussed in detail in Chapter Two) that suggests that individuals from Sub Saharan Africa, or at least certain regions, experience higher rates of stroke and type II diabetes (Lip et al 2007:184; Beune et al 2011:74), and also that those who have migrated are at greater risk than those who remained in SSA (Agyemang et al 2016). Given these potential health inequalities and the importance of ensuring preventive efforts meet the needs of a diverse range of individuals, it is relevant to explore the perceptions of a group of individuals who are transitioning from a context in which illness is understood primarily in terms of infection and transmission, to one where there is a larger focus on preventable NCDs.

A further important reason for studying the experience of ASRs from Sub Saharan Africa, is that they, like many other groups of migrants, are subject to many sources of vulnerability that may independently, and in combination, impact on health and engagement with healthcare (Pitkin Derose et al 2007:1258). It is for this reason, rather than for any sense of inherent similarity between them, that it is important to understand their experiences. As is described in the methods and results, the participants in this study are (amongst many other things) asylum seekers, refugees, black, and visibly and audibly foreign. They have varying levels of English, experience high levels of poverty, and live in some of the most deprived areas in Glasgow. They all have experiences of a different medical culture to that in the UK. Some have experienced gender-based violence; others are young men, isolated from most of the community services that might be able to assist them. Assumptions are likely made about the sorts of illnesses they are at risk of and the ways in which they understand their health. It is important, therefore, that this thesis acknowledges these intersections and the influence that they have on the findings generated. Therefore, this thesis considers how various aspects of ASR identity intersect with one another to shape experience rather than examining each aspect as an isolated issue. In taking this approach, it should be possible to move away from an individualist analysis to one that considers how multiple types of inequality combine to affect migrant health (Kapilashrami et al 2015:289; Virruel-Fuentes et al 2012:2103)

1.1 Refugees and asylum seekers in the UK

At the end of 2015 (the year for which the latest global figures exist), there were 65.3 million people who had been forcibly displaced, of which 21.3 million were classified as refugees by the United Nations High Commission for Refugees (UNHCR), 40.8 million were internally displaced, and 3.2 million were seeking asylum (UNHCR 2015:2). The current number of displaced people is the highest since the end of the second world war (UNHCR 2015:5), though the burden lies predominantly with countries in developing regions, where 86% of these individuals are being hosted (*ibid*). Thus, despite these high numbers, the proportion of these individuals that reach the borders of Europe and the UK is relatively small. The number of asylum applications across the whole of the EU in 2016 was approximately 1,189,000, with the UK receiving the eighth largest number (gov.uk/government/publications/immigration-statistics). There were 30,603 applications for asylum in the UK in 2016, the first fall in asylum applications since 2010 (gov.uk/government/publications/immigration-statistics). Per capita, this is a very small number of asylum applications: 6 per 10,000 population, as compared with an average of 26 per 10,000 across the 28 countries that comprise the European Union (Hawkins 2017:3). In 2016, 23% of these applications were made by individuals from countries in Sub Saharan Africa, including Zimbabwe, Eritrea, and Somalia (Hawkins 2017:3). However, despite this, both in Europe and the UK, migration has been one of the most significant concerns on the public agenda (Aspinall & Watters 2010:8; Rechel et al 2013; Blinder & Allen 2016).

With every wave of migration to the UK, there has been accompanying disquiet in public opinion, bolstered by the media (Greenslade 2005; Philo et al 2013). Rhetoric on migration in general but also toward refugees and asylum seekers specifically, has been particularly toxic over the past 15 years, with asylum seekers painted by both the media and policy makers as a burden on the state, untrustworthy, and solely in search of economic benefit (Bower et al 2009:25). This rhetoric has been coupled with increasingly restrictive and often dehumanising immigration policy intended to paint the UK as an unappealing prospect for migrants (Stewart 2005:502; Tyler 2012). Restrictive immigration policies were put in place by the Conservative Government in 1993 (Kushner 2003:260). The New Labour Government followed the path paved by the conservatives in *its* immigration policy, suggesting that asylum seekers presented a problem that needed solving, reinforcing negative public attitudes about migration (Mulvey 2010:437) and creating a sense of ‘moral panic’ (Stewart & Mulvey 2014:1024). A core aspect of New Labour’s

asylum policy was to reinforce the figure of the ‘bogus asylum seeker’, which, Tyler notes, conflated all immigrants in the UK into one single, undesirable ‘abject’ subject (Tyler 2013:76). The notion of the bogus asylum seeker was used to cast doubt on the veracity of individuals’ claims for refuge and justified the restrictive legislation put in place (ibid:79). Concurrent with government rhetoric that it was protecting the UK’s borders against an unwanted ‘other’, was a concerted media campaign which further delegitimised asylum seekers and hardened public opinion. While it could be argued that media representations reflected pre-existing attitudes towards migration, the volume of negative stories, including many whose claims were entirely baseless, certainly reinforced this (Allen 2016; Greenslade 2005). It is argued that the representation of asylum seekers in such a negative manner was intended to cast them as scapegoats, which would distract the public from concerns about the receding welfare state (Tyler 2013:93).

Stewart notes how the status afforded to asylum seekers - powerless non-citizens, untrustworthy, and at imminent risk of removal - puts them in a place of acute vulnerability where they do not enjoy the rights afforded to others in the UK (2005:501-2). The term ‘asylum seeker’ as distinct from ‘refugee’ was in fact only defined as a legal category in the UK when the Conservative introduced it into immigration legislation in 1993 (Kushner 2003:260). This created a group of people who were exempt from the protections provided to refugees through the 1951 refugee convention. Studying the impact of this political context on their health is therefore critical.

Throughout, this thesis considers the experiences of both refugees and asylum seekers. I use these definitions so as to make clear the status of the participants in terms of their rights and entitlements in UK law.

1.1.1 Refugees, asylum seekers and ethnic minorities in Glasgow

Though numbers are still low, migration has increased more quickly in Scotland than anywhere else in the UK in the last few decades (Migration Observatory 2014:2). Between 2004 and 2012 the population of Scotland with non-British nationality increased from 127,000 to 285,000 (Vargas-Silva 2013:2). With 86,000 non-British residents in 2012, Glasgow has the largest concentration of these individuals (*ibid*). Concurrently there has also been a sharp rise of people with non-white ethnicity in Scotland (Simpson 2014:1). In the 2001 census there were 5,000 individuals of ‘black African’ ethnicity in Scotland, and

this number had increased to 29,000 by 2011 (Simpson 2014:2), with the majority living in and around Glasgow. It is therefore a ‘community’ that is very new to the city.

The 1999 UK Immigration and Asylum Act marked a significant change in asylum policy that catalysed a process of asylum seeker dispersal across the UK. This was intended to lessen the concentration of ASRs in London and the South East, but was heavily criticised for removing individuals from places where they had connections and had been able to develop bonds (Bowes et al 2009:30). Glasgow was the first city council to offer to become a dispersal centre (scottishrefugeecouncil.org.uk). Prior to 1999 Glasgow had relatively limited experience of accommodating ASRs⁴ (Wren 2007:391), but it now has one of the largest concentrations of asylum seekers in the country, housing 3,311 asylum seekers in receipt of section 95 support⁵ at the end of 2016, the equivalent of 1.09 per 200 people (Lyons 2013). It is unclear exactly how many refugees live in Glasgow since there is a lot of movement post status and data are unreliable (Mulvey 2009:4), but there are estimated to be around 20,000 recognised refugees living in the city (Strang & Quinn 2014:5). Finally, there are also unknown numbers of undocumented migrants and destitute asylum seekers, following failed asylum applications.

The links between poverty and ethnicity in Glasgow are stark, with Netto et al noting that ‘all minority ethnic groups appear to be disadvantaged according to one or more indicators of poverty’ (2011:6). Individuals of ‘Black African’ ethnicity, for example, have an unemployment rate of 15% compared to 7% for the white Scottish population⁶ (Netto et al 2011:1617). They also experience higher rates of both poverty and material deprivation (*ibid*).

Public opinion toward migration in Scotland is generally thought to be more positive than in the rest of the UK, and politicians have drawn on this expression of positivity towards migrants (McCollum et al 2014:79). Research on Scottish public opinion corroborates this to a degree. Data from the British and Scottish social attitude surveys, suggest that attitudes in Scotland are ‘less hostile’ than attitudes in England (McCollum et al 2014:79).

⁴ The Scottish experience of welcoming refugees prior to dispersal was limited but largely positive. Between 1992 and 1996 Scotland housed hundreds of Bosnians fleeing the Bosnian war. Subsequently in 1999 Kosovans fleeing ethnic cleansing were housed in Scotland, particularly in Glasgow (scottishrefugeecouncil.org.uk).

⁵ Section 95 support provides accommodation and financial assistance to asylum seekers waiting on a decision for their claim.

⁶ Netto et al 2011 note that only half of this difference can be accounted for by age, family type or work status

However, this should not mask the fact that over the past decade there have been growing concerns expressed about the number of immigrants in Scotland especially with reference to their perceived impact on job availability and Scottish identity (McCollum et al 2014:90). Analysis by the Oxford Migration observatory suggests that 58% of the Scottish population would like to see migration reduced (Migration Observatory 2014:2). While this figure is lower than in England and Wales, where 78% of the population would like immigration reduced (ibid), it is still a significant number.

1.2 The Scottish policy context

There are important differences between Scottish and English approaches to migrants and migration, both in terms of rhetoric and in terms of policy. At the policy level the responsibilities governing refugees and asylum seekers are split between the Westminster and Scottish governments. Decision making around asylum status remains reserved to the UK Government, whereas issues related to service provision (excluding housing) are the responsibility of the Scottish Government (Mulvey 2009:11; Scottish Government 2013:23). This separation of responsibilities can bring to the fore tensions between the approaches of the UK and Scottish governments, which have become increasingly apparent over the past decade. The UK government which controls decisions about asylum status, and the level of support (financial and housing) to which asylum seekers are entitled has been overt in its intention to make the lives of asylum seekers difficult, so as to limit any ‘pull factors’ (Mulvey 2009:4). Conversely, the Scottish Government which controls integration, healthcare and other service provision has focused on prioritising the integration of all individuals who are living within the borders of Scotland. Scotland’s integration policy, ‘New Scots: integrating refugees in Scotland’s communities’ is aimed at both asylum seekers and refugees and intends to ‘enable all refugees and asylum seekers to integrate into the communities from day one of arrival and not just when refugee status is granted’ (Scottish Government 2017:20). Furthermore, integration in Scotland is considered to be a two-way process rather than solely the responsibility of the person integrating (Mulvey 2015:365). This stands in contrast to integration policy in England which begins only on receipt of refugee status and where asylum seekers are intentionally kept separate from the rest of the population (Allsop 2014:15).

The Scottish Government has stated a strong commitment to the health, wellbeing, and social inclusion of both refugees and asylum seekers in Glasgow (Strang & Quinn 2014:5). Indeed, between 2001 and 2013 it invested over £13.5 million in order to aid ASR

integration (Scottish Government 2013:23). There is now a plethora of organisations in Glasgow that support ASR residents over and above any statutory provision, and a number of fora that coordinate between state and third sector providers, such as the Scottish Refugee Integration Forum (Roshan 2005:15). Indeed, many projects have been developed that have brought together organisations across the spectrum, including the Holistic Integration Service⁷ which helped 1,885 people between May 2013 and 2016 (Strang et al 2016:5), and the Refugee Peer Education for Health and Wellbeing Project⁸. Asylum seekers in Scotland are therefore caught between two very different narratives. They are subjected to dehumanising processes through the actions of the UK Home Office, but are concurrently offered support in Scotland through a variety of statutory and voluntary channels.

1.3 Problematising key terms: culture, ethnicity, and race

Ahmad notes that instead of talking about ‘structure, power, and racism’ in health research, we instead talk about ‘culture, ethnicity, and difference’ (1996:198). It is true that a focus on ethnic and cultural differences risks locating health outcomes at the level of the individual and obscuring the structural determinants of a particular outcome. It is essential to maintain a focus on the imbalances in the distribution of power and resources that lead to unequal health outcomes. However, being cognisant of this does not mean that concepts such as culture and ethnicity do not hold any salience – indeed many people feel strong attachments to both their ethnicity and their culture (Kelleher 1996:77) - but that they must be considered in a critical manner. I therefore discuss here some of the debates surrounding the terms culture, race, and ethnicity and clarify their meaning in this thesis.

1.3.1 Culture

Taking account of culture, defined in this thesis as ‘not only habits and beliefs about perceived wellbeing, but also political, economic, legal, ethical, and moral practices and values’ (Lancet Commission 2014:1607), is critical in ensuring that healthcare and health research resonate with individuals’ lived experiences and can be integrated in meaningful

⁷ The Holistic integration service is a ‘unique partnership led by the Scottish Refugee Council with British Red Cross, Bridges Programmes, Glasgow Clyde College and Workers Educational Association’ (Strang et al 2016:5)

⁸ This collaboration between NHSGG&C and the Scottish Refugee Council trained two cohorts of refugees to be peer educators on health and wellbeing issues and health access (Strang 2015:6)

ways (Lancet Commission 2014:1608). However, the manner in which culture is conceptualised has a profound impact on the success with which this is done. Ahmad warns against a 'rigid' conceptualisation of culture in health research, where culture is seen as a set of rules by which people can be understood, since this can lead to research and practice being carried out in a manner that pits 'them' against 'us' (Ahmad 1996:190). The way in which culture is understood has considerable implications for healthcare (Castañeda 2010:7). The assumption is often made that 'culture' is a critical factor in explaining barriers to health services access or poor health outcomes, without any attempt to critically interrogate what that means (Virruel-Fuentes et al 2012:2099). Often, culture is understood as a static set of assumptions about a 'group' of individuals. This is problematic for two reasons. The first is that this can lead to stereotyping and inappropriate assumptions being made about an individual's behaviour, based on which cultural group they are considered to be a part of (Lambert & Sevak 1996:124). Secondly, culture itself can be used as an explanation for poor health outcomes, subtly invoking blame for that health outcome and obscuring many other relevant reasons for poor health outcomes (Castaneda 2010:7; Zhou et al 2016:1067). Particularly concerning is that such explanations are often used to mask or underplay the influences of social and economic inequality in producing unequal health outcomes thus absolving policy makers from having to address these issues (Hirsch 2003 in Castañeda 2010).

Anthropological research has been instrumental in exposing the complex, contested, and fluid nature of 'culture', whilst simultaneously acknowledging its relevance for individuals' lived experience of health and wellbeing. Importantly, culture influences the way that *all* actors and institutions interpret notions of health and wellbeing, it is not static nor can it be reduced to a set of attributes through which we understand different groups of individuals.

It is important to understand the ways in which culture manifests itself in research participants' lives and the ways that they themselves conceive of the meaning of culture. In his ethnography of Southall, London, Gerd Baumann notes that the inhabitants of Southall reified notions of culture and cultural 'difference' whilst simultaneously breaking those notions down in their discourses (Baumann 1996:11). It is critical to remember that while culture might not be understood as real or solid in anthropological analyses, it might be understood in a very solid way by research participants, as it is in dominant discourses, (Baumann 1996:188) and this should not be undermined. It is equally important to remember that increased attention to culture, while problematic, has led to significant

improvements in health provision and to an awareness that practices that may have once been considered strange or wrong, are in fact coherent in a different context (Kelleher 1996:83). Norms around the ideal female body shape, which is fit and slim in the Western world, but larger (to signify a husband's wealth) in other parts of the world could be considered in this way.

A significant concern regarding the way that culture is used in healthcare is the risk of creating a dichotomy between a 'group' of migrants or an ethnic minority who have one 'culture' and the rest of the population that has another. This process of 'othering' is problematic for a variety of reasons, not least because it can play into broader negativity towards migrants and create more barriers rather than fewer to access and engagement with health. More helpful is to understand culture as an attribute that affects all institutions and individuals, not just as a subjective notion that affects relationships with objective realities or conversely as an innate or unchanging characteristic (Lancet commission 2014: 1614).

It is important, therefore, to find a research position that neither ignores the relevance of culture, nor prioritises it at the expense of structural explanations (Hadley 2010-2-3), but rather understands it as a pervasive but dynamic facet of all areas of life. As I discuss in Chapter Three, approaches from critical medical anthropology allow us to explore the ways that culture shapes individual lived experience without forgetting the structural context in which this occurs.

1.3.2 Race and ethnicity

The idea that race is a coherent and natural entity has largely been discounted in the UK, and considered of little relevance to understanding variations in health and illness (Bhopal 2003:442). That is not to say that racism, predicated on the idea that there are real, natural, and hierarchical differences between certain groups of people does not continue to impact on health. Indeed, there is a wealth of evidence from around the world to suggest that it does (DeIVecchio Good et al 2005:396). Instead of race, the concept of ethnicity now holds significant currency in the epidemiological literature (particularly in the UK and Europe), though there is continuing debate firstly about how it should be defined and secondly about what ethnic categories should be used (Bhopal 2003:441). Geertz described ethnicity as the 'world of personal identity collectively ratified and publicly expressed' –an identity that is personal and social, individual and collective (*in* Jenkins 1996: 70). Bhopal provides some more specificity considering it to be a 'multi-faceted quality that refers to

the group to which people belong, and/or are perceived to belong, as a result of certain shared characteristics, including geographical and ancestral origins, but particularly cultural traditions and languages' (Bhopal 2003:441). What is important about both of these definitions is that ethnicity is constructed both internally and externally and that it is used to define a 'group' that has a number of common features.

In addition to socioeconomic inequalities in health, a strong tradition of ethnicity and health research in the UK has demonstrated the numerous health inequalities (both in terms of health outcomes and access to care) experienced by individuals from certain minority ethnic groups (Mir et al 2012:504). This has been useful in shedding light on poor health outcomes that cannot be explained by socioeconomic status alone and has provided an opportunity to examine how a host of factors intersect to shape the experiences of ethnic minorities (Karlsen & Nazroo 2007:21).

Ethnicity is a useful category in the way that it enables us to identify aspects of inequality that cannot solely be explained by socioeconomic status. Ethnic categorisations must not be used uncritically however. As with race previously, there is a risk that ethnic categories will be seen as natural and static entities rather than socially and epidemiologically constructed and in turn ethnic differences in health will be considered natural as well when in fact they are structural (Mir et al 2012:506; Salway & Ellison 2010). When using the term ethnicity, it is critical to ensure that it is not reduced to a biological construct but understood within the particular social, cultural, and economic context that shapes it (Karlsen & Nazroo 2006:27). While it would be wrong to deny any genetic basis to certain health outcomes (e.g., the high rates of CVD amongst South Asians), the structural causes of health inequalities are equally critical. As with the concept of culture, ethnicity is not static, homogeneous, or 'natural' (Mir et al 2012:505).

An important and useful aspect of the category of ethnicity is that rather than it being a solely externally imposed category, the term also incorporates an element of internal identification (Jenkins 1996: 76; Karlsen & Nazroo 2006:22). Individuals choose the ethnicity to which they feel they belong (e.g., Black African, or Black British) rather than having it decided for them. This element of internal identification ensures that it has much more resonance as a category to people than race (Nazroo 1998:712). Because ethnicity is partly about shared characteristics, there are concrete aspects to which people feel attached (Modood 1996:95). Ethnicity is not just internally defined, however, but it can be considered as structurally defined as well (Karlsen & Nazroo 2002). The structural position

in which ethnic minorities find themselves, through no decision of their own (e.g., subject to institutional racism), can have a significant impact on health and access to care.

The participants in this study are defined as being part of an ethnic group – ‘black African’ – and also by their migration status. Taking a critical view of ethnicity (as described above), it is then important to understand how ethnicity and migration status intersect to shape the needs of these participants (Jayaweera 2010:2).

1.4 Aims and research questions

As previously described, this thesis examines the health and healthcare experiences of asylum seekers and refugees (ASRs) from Sub Saharan Africa (SSA) living in Glasgow, Scotland, with particular reference to what it means to keep healthy, and how one might address lifestyle risk factors associated with non-communicable diseases. The research had five high level aims, with four specific research questions designed to address the aims:

Aims:

- To explore what it means to be healthy, and how health services are accessed.
- To elucidate understandings around prevention of NCDs.
- To compares ASR perceptions to those of health professionals.
- To explore how wider structural determinants shape understandings and experiences of health, and influence health outcomes.
- To gather evidence to aid the development of interventions to prevent NCDs amongst vulnerable and marginalised groups.

Research questions:

1. What does being ‘healthy’ mean to asylum seekers and refugees from Sub Saharan Africa in Glasgow?
2. What are ASR experiences of using primary and preventive health services?

3. What impacts on ASR capacity to keep healthy and access healthcare services?

4. How do health professionals in Glasgow talk about refugee health and access to care?

1.5 Format of the thesis

Chapter Two situates the thesis within the broader literature on i) access to primary and preventive care, and ii) perceptions of health, wellbeing, and prevention for refugees and asylum seekers. I first examine broad trends in the migrant health literature, incorporating work from the UK, USA, Europe, and Australia. I then narrow down to focus on the experiences of ASRs in Glasgow and the wider UK. Literature from international settings is relevant in that the different approaches taken offer the potential for shared learning. Additionally, due to the fact that asylum policy is made at a UK rather than a Scottish level many of the same issues affect refugees and asylum seekers across the UK. I argue that this literature has too often focused on the biological, behavioural, and cultural determinants of migrant health rather than its structural determinants. I address this issue in the second half of Chapter Two, drawing on the small literature that has taken an inequalities approach to migrant health and elucidating the various structural factors that have been suggested to impact on ASR health.

Chapter Three sets out the theoretical underpinnings of the thesis. I focus on two theories that I suggest, in combination, have the potential to frame research that can provide a comprehensive picture of engagement with health and healthcare. The first of these is ‘candidacy’ (Dixon-Woods 2005): a theory of access to healthcare that follows an individual’s path, in seven stages, from identifying themselves as a candidate for a particular service to receiving that service. While candidacy has been useful in service user-provider engagements, it has also been criticised for failing to take into account the macro-level determinants or wider contextual influences on service access. I therefore draw on a second theory, that of structural vulnerability (Quesada et al 2011), which provides a lens through which to explore critically the macro-level factors that make individuals vulnerable to poor health and healthcare access. I suggest that combining these two approaches will allow me to explore how access to healthcare and perceptions of health are shaped at the micro-, meso-, and macro-level, and how these levels interact to either reinforce or undermine each other.

Chapter Four outlines the methodology deployed in the thesis, which is a ‘focused ethnography’. I describe how I developed methodological tools that allowed me to combine methods from critical medical anthropology with an applied health focus. I also discuss the ethical issues inherent in conducting research with vulnerable and/or marginalised communities.

Chapters Five, Six, Seven, and Eight present the results of the focused ethnography, which I separate into three separate but interlinked topics. While the primary focus in these chapters is on the words of the ASR participants, I draw throughout on the perspectives of professionals in public health and primary care to examine where perceptions converge and diverge.

Chapter Five describes the layout of the results chapters, offers biographical details of the participants, and presents some overarching narratives.

Drawing on the early stages of the candidacy framework, in particular identification of candidacy, Chapter Six presents the ASR participants’ perspectives on what it means to be healthy and prevent illness, on the various health practices that participants considered relevant to health, and on the extent to which they were able to engage in these practices. These narratives are compared and contrasted with professional (primary care and public health) perceptions of ASR health.

Continuing to later parts of the candidacy framework, Chapter Seven considers experiences of access to formal services – primary and preventive healthcare, and social support.

Chapter Eight brings in the theory of structural vulnerability to explore the wider environment in which the ASR participants are made vulnerable to poor health and/ or suboptimal healthcare. I explore how a variety of structures (poverty, racism, neighbourhood environment, the experience of migration) impact on the ways that ASRs understand their healthcare and engage with what it means to be healthy.

The thesis concludes with with a discussion in Chapter Nine. I first consider some of the ethical concerns associated with conducting research with vulnerable and marginalised communities and reflect on the methodological approach of the thesis. I then draw my two theoretical frameworks together, exploring the extent to which candidacy is a useful framework for understanding ASR experiences of preventive care, and considering where

the data require that modifications are made. I develop a modified version of candidacy in which the relationship between the micro- and macro-level is made explicit at each stage, and in which preventive care fits more easily, I additionally suggest that by exploring ASR health through the theories of candidacy and structural vulnerability, the role of the asylum system as a determinant of health is writ large, and I discuss the various mechanisms by which this manifests itself. Lastly I consider what wider lessons this research might offer for other marginalised and minority groups.

Chapter Two: Literature review: health, prevention, and access to healthcare

As described in the introduction, this thesis examines the experiences of asylum seekers and refugees (ASRs) from Sub Saharan Africa (SSA) in Glasgow with regards to i) what it means to keep healthy, ii) how primary and preventive care are accessed, and iii) what wider factors influence health and access to care.

The aim of this chapter is to situate refugees and asylum seekers from Sub Saharan Africa in Glasgow, not only in terms of what is already known about their particular experiences, but also in terms of the literature on migration and health more broadly. After first assessing some general trends in research on migrant, refugee, and asylum seeker health, I move on to consider access to primary and preventive care. I explore literature from Europe, North America, Australia, and New Zealand here. Although histories of migration have been very different across these continents, I argue that there is much to learn from the various approaches that have been taken. I then narrow my focus to the UK, Scotland, and Glasgow exploring the factors that shape ASR health in this context, and then specifically the health of ASRs from Sub Saharan Africa. Palinkas et al suggest that the three health issues relevant for migrant health are psychiatric, infectious, and chronic disease (Palinkas 2003:19). While the literature reviewed in this chapter covers aspects of general wellbeing, in order to meet the purpose of the research reported in this PhD, it is focused more on chronic NCDs, rather than psychiatric or infectious diseases.

Through a critique of this literature, I argue that there has, to-date, been an insufficient focus on the broader determinants of ASR health, with attention still too often falling on cultural and behavioural factors rather than the environments that shape them. Where broader environments are mentioned this is often considered to be a side note, rather than central to the study, which means that preventive health solutions are still directed at the individual level.

Having grounded my research in the literature on migrant health, I will proceed in Chapter Three to consider how a theoretical framework might be developed that allows us to explore issues around access to care and resources, whilst integrating a macro-level perspective.

2.1 Scope of review and search strategy

The body of literature on refugee and asylum seeker health covers a broad range of topics, and this review is necessarily broad in nature. Due to this breadth, and because this literature review was seeking to set the context for the research, I determined that a narrative approach would be a more appropriate method than a systematic review. Focusing on literature from public health, primary care, and health services research, the review covers:

1. Access to primary care for migrant groups
2. Primary prevention of NCDs in migrant groups
3. Factors influencing health and wellbeing of ASRs

While I did not use a systematic review methodology, I carried out the literature search in a systematic manner. My intention was to retrieve both academic and grey literature, and I used a variety of methods to do this:

- a) I developed a series of search strings based on the above topics which I used to search the major health and social science databases - SocIndex, Web of Science, Medline, Cinahl, Science Direct, and Google Scholar⁹.
- b) I searched these papers' bibliographies for articles that might have been missed.
- c) I looked at the bibliographies of specific authors where I was aware (either from my own previous research or on the recommendation of supervisors) that they had conducted significant research in this area.
- d) I retrieved additional grey literature through hand-searching the publications sections of various relevant statutory and third sector organisations, such as NHS Greater Glasgow and Clyde Health Board (NHS GGC), and the Scottish Refugee Council.

While the core focus is on the health of refugees and asylum seekers in the UK, I have, where relevant, expanded outwards to cover a) literature on other migrants and ethnic minorities, and b) literature from the USA, Europe, Australia and New Zealand, as this can be helpful for highlighting trends in the UK literature.

⁹ see Appendix J for full list of search terms

There are a number of large bodies of literature that are not explicitly included, though discussed where relevant. These choices were influenced by the research questions of this study. Thus I have not addressed in detail work on mental health in ASR populations or on implementation and use of interpreters and interpretation in healthcare, since these are extremely large literatures in themselves and beyond the scope of the review.

2.2 Broad trends in migrant health research

Though there is little agreement on what, precisely, they are, there is consensus in the literature that migrants¹⁰ are part of a ‘vulnerable population’ that faces specific health needs, and that inequalities exist in terms of both access to care and health outcomes between migrants and non-migrants (Mladovsky 2007; Pitkin Derose et al 2007:1258; Rechel et al 2011a; Bhopal 2012; Ingleby 2012a). Health inequalities are defined here, as ‘the systematic differences in health which exist between different population groups’ (Smith et al 2016:1) In the context of the increasing diversification of migrant flows and the increasing diversity of individuals with which health systems must work, these factors combine to mean that migrant health is a field of research that is considered to be growing in importance (Abubakar et al 2016; Hanefeld et al 2017; Rechel et al 2011a).

A number of broad trends can be identified in approaches to migrant health. It is relevant to elucidate them here briefly, in terms of how they play out in the UK, since they help to contextualise some of the literature that is to follow. ‘Migrant’ is, of course an extremely broad category, and includes those moving for work, for study and for family reunification (ec.europa.eu¹¹). Although the focus of this thesis is specifically on ASRs, much of the broader literature still holds relevance, and in fact often does not clearly distinguish between types of migrants (Rechel et al 2011b:85). In reading this literature, some key trends are apparent. These include: i) a historic focus on minority ethnic rather than migrant health in the UK, ii) a division between health inequalities research and migrant health research, iii) concerns over a lack of rigorous epidemiological data, and, iv) a strong focus on culture and cultural competence.

¹⁰ See list of definitions for discussion of the meaning of “migrant” and related terms.

¹¹ Full ref: http://ec.europa.eu/dgs/home-affairs/e-library/docs/infographics/immigration/migration-in-eu-infographic_en.pdf

2.2.1 Migrant health vs. ethnicity and health

While the United States has a long history of migrant health research (Ingleby 2011:228), this has been less apparent in the UK or Europe, at least until more recently. One reason for this is likely to be that the UK has traditionally focused on ethnicity as the variable under consideration (Jayaweera 2010:1; Salway et al 2011:518). This body of research has helped uncover important ethnic variations in health, such as the significantly higher rates of CVD and diabetes amongst South Asians (*e.g.*, Bhopal 2001), and higher rates of stroke amongst individuals of black ethnicity (Lip et al 2007:184). Numerous explanations have been drawn on for such phenomena, ranging from the biological to the structural. However, the focus on ethnicity means that factors related to migration and migration status are often overlooked (Salway et al 2001:515). For example, there has been limited work done to uncover what aspects of migratory experience might contribute to poor health outcomes (or conversely act as a protective factor) although there are notable exceptions such as Zimmerman et al's 2011 paper on the three phases of migration that impact on migrant health (Zimmerman et al 2011). As a result, the vast majority of evidence that contributes to health policy is based on ethnicity and does not consider the impact that migration might have had on health outcomes or healthcare use (Jayaweera 2010:2). This can in part be explained by the fact that although good data on ethnicity can be obtained through the census (Bradby & Chandola 2010:33), data on migration (as discussed below) is significantly less robust, or, in many cases, absent altogether.

Although there is a heavy weighting towards research on ethnicity rather than migration, Lip et al caution that the evidence base, even for this category is poor with regards to the effectiveness of health interventions (Lip et al 2007:203; Salway et al 2013:331), and significant ethnic inequalities in health still persist (Salway et al 2013:331). When migrant health has been a focus, the most common topics have been mental health, maternity care, and infectious diseases (Bradby et al 2015:6; Castañeda 2010:16). While not exclusively the case, the focus on ethnicity rather than migration is particularly evident in research on NCDs (*e.g.*, Netto 2010) and there is little or no quantitative data in the UK on NCD risks for different migrant groups (Jayaweera 2014:2). Some work has been conducted in other European countries, notably the Netherlands and Norway. For example, Agyemang et al found that while the prevalence of hypertension amongst Ghanaians living in the Netherlands was 55%, only half were aware they had the condition, and only 45% of those were receiving medication (Agyemang et al 2012). Diaz et al examined the prevalence of multimorbidity amongst different migrant groups in Norway. They found that, comparing

for family reunification, multimorbidity was lowest amongst those moving for work or education, and highest amongst refugees (Diaz et al 2015). Findings such as this caution against regarding migrants as a homogeneous group with similar risks and disease profiles.

2.2.2 Divisions between migrant and ethnic minority health and health inequalities research

A second long-term trend in the UK and Europe is the division between those who do research on the social determinants of health (SDH) and traditionally focus on socioeconomic status as the key factor in causing disparities, and those who research migrant and ethnic minority health (Malmusi et al 2010). The result of this division is that ethnicity and migration status have been insufficiently considered as a determinant of health inequalities by SDH researchers, and migrant health has been insufficiently considered from an inequalities perspective by migrant health researchers. Health inequalities research has focused largely on socioeconomic disparities (Leveque 2012:53), with any variation by ethnicity or migration status being explained in terms of socioeconomic factors. While it is acknowledged that socioeconomic status does play a role in explaining health inequalities experienced by ethnic minority groups (Karlsen & Nazroo 2002:2), it is far from the only factor (Nazroo 1998:710) and many others have emphasised specific aspects of ethnicity (e.g., cultural factors, racism, genetics) that contribute significantly as well (Nazroo 2003: 277; Karlsen & Nazroo 2002:2).

The limited attention that health inequalities researchers have paid to migration and ethnicity has been noted and criticised. Ingleby, in his critique of the final report from the Commission on the Social Determinants of Health published in 2008, points to the lack of consideration of migration in the document, whether as a social determinant or not (Ingleby 2012b). Salway also levelled similar criticisms (Salway 2010 *in* Jayaweera 2014:7). This position appears not to have improved, as evidenced by a recent paper by Castañeda et al, who argue that ‘The lack of dialogue between these two profoundly related phenomena – social determinants of health and immigration – has resulted in missed opportunities for public health research, practice, and policy work (Castañeda et al 2015:375).

2.2.3 Concerns around data and definitions

Issues and challenges around data operate at several levels, at least in the UK. First, accurate data on ASRs are difficult to obtain: although data is collected on numbers of

asylum applications, acceptances and refusals, there is no clear information how many destitute or undocumented migrants there are, nor on how many recognised refugees are in the UK. As a result, the capacity of researchers to do research on refugee and asylum seeker health is hampered (Correa-Velez & Gifford 2007:273). There are a number of potential reasons for this. Most significantly, collecting data on ASRs is highly complex and there are limited resources with which to do it. It is understandably difficult to collect data on individuals who are not in the system (e.g., undocumented migrants), and the UK census does not provide clear data on country of origin or migrant status. In addition, individuals often transition between different migrant statuses, which is very difficult to monitor. A further potential reason, though not one that should be overstated, is suggested by Correa-Velez & Gifford. They question whether the lack of data is partially intentional, since without accurate statistics it is easier for a government to control the narrative on how many refugees and asylum seekers there are, which may be politically useful. Secondly, since many of the rules to which migrants are subject have a negative impact on their health, it may be in the interests of governments to limit capacity for research that will uncover this (Correa-Velez & Gifford 2007:273).

In addition to the deficiencies in data on ASRs in particular, concerns exist around migration data more broadly (Rechel et al 2012). These concerns relate to problems around the definition of 'migrant' and the limited volume of data collected. The term 'migrant' masks enormous heterogeneity, both within and between different groups of migrants (Abbott & Riga 2007:937; Anderson & Blinder 2017:2; Rechel et al 2011b:85), but it is often used as the unit of analysis, instead of being stratified by type. Further, there is no internationally recognised definition of the term 'migrant' (Rechel et al 2012:11). This makes it very hard to draw reliable conclusions (Lay et al 2006:20; Jayaweera 2010:2; Leveque 2012: 54). Additionally, the way that the term 'migrant' is defined varies not only from country to country (Bradby et al 2015:3; Ingleby 2011:227; Rechel et al 2011b:84), but also by different institutions in the UK (Anderson & Blinder 2017:2). Just within the UK, the Labour Force Survey and Annual Population Survey use country of birth, National Insurance number applications collect data by nationality, and the ONS focuses on length of stay in the country (ibid:3). Beyond definitions, the processes associated with migration, such as the ideal role of the government or strategies towards integration vary as well (Salway et al 2011: 515). There are also very little data collected in other countries. Rechel et al note for example that only 11 out of the 27 EU member states collect information on healthcare use by migrant status (Rechel et al 2012: 10). Rechel et al are critical of the limited efforts that have been made to improve data collection since it reduces

opportunities for improvements in migrant health (Rechel et al 2011b: 95; Rechel et al 2012). They do note, however that the UK is ahead of other EU countries in collecting population data by migrant status (Rechel et al 2012:11).

A dearth of comparable data presents a challenge in terms of making cross-country comparisons, and as a result, there has been limited research in this area (Becares et al 2012:2107; Salway et al 2011: 515). There are recent exceptions to this however. Examples of the potential of such work include the EU-funded COST and RESTORE studies (Ingleby et al 2012; O'Donnell et al 2016). In addition to insufficient cross-Europe comparative work, Netto notes the lack of comparison between research being carried out with migrants in Europe and that being carried out with migrants in North America (2012:266). Given that North America has a longer history of migrant health research (Ingleby 2011:228), there are likely missed opportunities from this lack of comparison. Indeed, the use of concepts such as 'structural violence' in the American literature on migrant health (as detailed in Chapter Three) might provide extremely useful insights into the health of various migrant groups in Europe.

Despite agreement that a focus on migrant health is critical, the lack of an evidence base in migrant health is a constantly cited concern, particularly in the European literature (Jayaweera 2010:2; Rechel et al 2011a:23). Though data are sufficient to demonstrate clear inequalities (Bhopal 2012:27), evidence deficits exist across numerous areas, from a lack of knowledge about the illnesses that disproportionately affect migrants, or particular groups of migrants (Bhopal 2012:25), to insufficient evidence on which services or interventions might be effective in improving migrant health (Bhopal 2012; Ingleby 2012a; Netto 2012). Calls for further qualitative and quantitative research are thus made throughout the literature (Netto 2012:266; Feldman 2006:809).

2.2.4 Culture and cultural competence

A final key trend in the literature on migrant health, both in the UK and further afield, is the discussion of culture as a factor in shaping both perceptions of health and engagement with healthcare. This is coupled with a vast literature on 'cultural competence' in healthcare provision and the development of a range of culturally competent interventions that address either deep or surface level culture (Netto et al 2010: 249). It is beyond the scope of the review to assess this literature in detail here, but there are several relevant points to be made. Durieux-Paillard stresses that healthcare providers must understand the

ways in which clinical practice is affected by cultural diversity. Based on that understanding, it must provide “culturally responsive healthcare” that extends beyond simply providing care in the service users’ language (Durieux-Paillard 2011: 203) as this alone cannot mitigate misunderstandings based on cultural differences. Whilst this is clearly an extremely important aspect, there are many traps which migrant health research can fall into. The first is assuming that a particular ethnic or migrant group is culturally homogenous, and subscribes to a certain set of cultural ‘values’ that do not change and that can be considered in a checklist fashion (Castañeda 2010:13). Secondly it is critical to remember that all individuals, groups and organisations are part of one or several cultures, and it is not just the culture of the migrant that must adapt, or be deconstructed but the culture of the professionals and the organisations with which they are engaging (Lancet 2014). A final pitfall is to overemphasise the importance of culture as an explanation for health outcomes, since it can mask structural determinants of health inequalities and instead locate problems within the individual (Castañeda 2010:7; Durieux-Paillard 2011: 209).

2.3 Access to primary and preventive care

Access to healthcare has been a focal point for much of the literature on migrant health, with research examining barriers and facilitators to access, and what models might best assist access to primary and preventive care. Although there is a reasonably large literature on access to primary care for migrants, literature on preventive care focuses more closely on the needs of ethnic minority groups (Jayaweera 2014:2).

There are a number of broad, concerns about the access to care literature. It is noted that while the health needs of ASRs are well documented, there is insufficient analysis or evaluation of what interventions might effectively improve ASR health (Feldman 2006:810; Joshi et al 2013:99). Additionally, since studies tend to be carried out at the point at which individuals are accessing services, it is harder to gain data on those who do not reach that point (Aung 2010:285). Research that has sought to address issues related to access often focuses excessively on the role of the patient, without considering the broader issues that might affect access. Norredam, for example, discussing barriers to care for migrants divided them into issues such as ‘language’ ‘communication’, ‘newness’ and ‘sociocultural factors’ (Norredam 2011:72) but excluded structural and economic factors, or those to do with the complexity of being a migrant. Chase et al note that access to care for migrants has rarely been considered in a uniform or structured way, but looks at either

barriers or utilisation without consideration of the dynamic between the two (Chase et al 2017:53). Whilst further research is called for both on the best methods for service provision (Jayaweera 2010:4) and the best ways to develop health interventions for migrants (Netto 2012:265), certain aspects of best practice are emphasised. In particular language and cultural ‘barriers’ are regarded as critical issues, along with the physical accessibility of services, and therefore services that make provisions in these areas are deemed to be preferable (Joshi et al 2013:88; Pavlish et al 2010: 359; Rechel et al 2011a:6; Kallayova and Majdan 2012:300).

2.3.1 Access to primary care

Primary care is often the first point of entry to healthcare for many ASRs, especially in the UK (Burnett & Fassil 2001; O’Donnell et al 2016), though as discussed in Section 2.2.3, the lack of data or monitoring by migrant status hampers attempts to meaningfully monitor healthcare use by ASRs. A systematic review by Uiters et al tried to compare primary care use by migrant groups to that of the majority population of the country (Uiters et al 2009). Comparing a range of outcome measures, including GP visits and A&E usage, they found no consistent patterns of migrant use. The only exception was studies from the United States which were more likely to report lower use of primary care by migrant populations. However, there was no clear definition of a migrant group, and all studies appeared to report on slightly different population groups. Likewise, a review of European literature on healthcare use by adult first generation migrants compared to non-migrants found a diverging picture, with no clear patterns of use (Norredam et al 2010). They did suggest, however, that migrants used GP services more, but had a lower uptake of preventive services such as cervical screening and mammography. These findings are supported by another, more recent systematic review (Graetz et al 2017). In this review of 39 papers comparing healthcare access of migrants with non-migrants, use of A&E services was higher; use of GPs was variable, but tended towards higher; and uptake of screening services was lower.

Chase et al also note the poorer than average use of healthcare systems by ASRs (2017:53). Although they are writing about Canada, they suggest that there is evidence of this trend throughout the ‘West’ (2017:53). Though data on use are scarce, what information does exist suggests that migrants in general make limited use of preventive services, including screening and vaccinations, and greater use of primary and emergency care – there is,

essentially, over use of certain services and underuse of others (Bradby et al 2015:7; Norredam & Krasnik 2011:69).

Few studies, certainly in Europe, are able to compare different migrant groups due to the aforementioned difficulties in data monitoring. One exception is Norway, where electronic registry data includes migrant status. This showed that, overall, migrants had lower contact rates with primary care than native Norwegians. Sub-analysis of two migrant groups uncovered a degree of complexity, however: Polish and German migrants, mainly work migrants, had much lower rates of contact while Somali and Iraqi migrants, mainly ASRs, had much higher rates of contact (Sandvik et al 2012). These findings highlight the complexity of migrant use of primary care and the heterogeneity masked by the term migrant. This issue is important not only in terms of healthcare use and entitlement but also migrant health more generally.

2.3.2 Factors impacting on healthcare use

It is generally agreed that the needs of ASRs are inadequately met by health services and that ASRs are not able to engage with care in an optimal fashion (Phillimore et al 2010; Feldman 2006:810). Several reviews - systematic and narrative – have identified a range of barriers facing migrants, including ASRs, when accessing healthcare. These are summarised in Table 1.

The reviews, together with the wider literature, suggest numerous barriers to access at the level of the patient, provider, and health system. On the health system side, these include lack of adequate information provided to ASRs about how the healthcare system works, limited provision of interpreters, lack of cultural sensitivity on the part of healthcare providers, complex procedures for registering with GPs, and limited awareness about ASR entitlements. On the individual/ patient side obstacles include financial poverty, limited health literacy, and knowledge of the health system. It is important to consider barriers at all levels from the individual to the structural and indeed health and migration policies in different countries have a significant impact on ASRs' ability to access healthcare (Bradby et al 2015:7; Cristancho et al 2008:634). However, most literature still tends towards the micro- or meso-level rather than the macro-level.

Paper	Aim and methods	Findings	Barriers to care
Uiters et al. 2009.	<p>To conduct a systematic review of research on the differences in primary care utilisation between immigrant groups and the majority population.</p> <p>37 studies from 7 western, industrialised countries were included in the review</p> <p>Studies that included undocumented migrants, homeless people, or people with disabilities were excluded.</p>	<p>Studies in the US were considerably more likely to report lower use of healthcare services by migrants than studies in the other countries.</p> <p>Fewer differences were reported between migrant groups in the same country.</p>	<p>Suggestion that strength of the primary care system may correlate with levels of healthcare access for migrants; differences in cultural values; language barriers</p>
Norredam et al. 2010.	<p>To conduct a systematic review of European literature on utilisation of somatic healthcare services by adult first generation migrants and identify differences between migrant and non- migrant service utilisation</p> <p>21 studies from 6 European countries published between 1998 & 2008 were included.</p>	<p>Studies varied considerably with regards to topics covered and migrant characteristics. There were found to be much lower levels of screening amongst migrants compared to non-migrants. Primary care and A&E utilisation appeared higher, though varied, and hospital utilisation showed no clear pattern.</p>	<p>Formal barriers: healthcare system organisation; legal restrictions on access; cost of treatment; lack of referral between services.</p> <p>Informal barriers: language and cultural obstacles; lack of information about services; challenges making appointments.</p>
Agudelo-Suárez et al. 2012.	<p>To conduct a metasynthesis of qualitative research on barriers to and determinants of economic migrants' access to health services to determine what factors affect access to services.</p> <p>28 articles published between 1997 and 2011 were synthesised, of which 12 were from the US and the other 16 from Australia, Canada, Israel, the Netherlands, New Zealand & Spain.</p>	<p>Numerous barriers to care were described at the structural/ political level, the organisational level, and the individual level.</p>	<p>Knowledge of the health system; language & cultural barriers; discrimination; economic barriers; migrants' legal status; lack of clarity over entitlements; lack of information on services; geographical barriers.</p>
Joshi et al. 2013.	<p>To conduct a narrative synthesis of studies (academic & grey literature) evaluating models of primary healthcare provision for refugees determine which components have increased access and quality of care.</p> <p>25 studies conducted between 1990 and 2011 were reviewed, including 10 from Australia and 15 from overseas.</p>	<p>Several elements of good practice in provision of care for refugees were identified, including integration between health & social care services, provision of care in the local area, and good patient-provider communication.</p>	<p>Fear & distrust; negative experiences of health providers; lack of confidence; sociocultural barriers; political, economic and administrative obstacles to accessing care.</p>

Woodward et al. 2014.	To conduct a scoping review of research on health and access to care among undocumented migrants to establish the extent, nature, distribution and findings of the literature 54 studies from the EU27 published between 1990 and 2012 were reviewed. Papers that did not disaggregate by migration status were excluded	Quantitative findings on access to care were mixed, with 2/4 quantitative studies showing an association between migrant status and healthcare utilisation. Qualitative studies demonstrated a number of obstacles to care, with continuity of care, hospital treatment and access to dental services particularly problematic.	Lack of awareness of legal entitlements among undocumented migrants & healthcare providers; lack of guidelines on treatment options; fear of being reported to authorities; costs of care &/or medicines; cultural and language barriers.
Graetz et al. 2017.	To provide a systematic review of evidence on health service utilisation by migrants in Europe and examine differences in usage between migrants and non-migrants 39 studies from nine countries published between Jan 2009 & April 2016 were reviewed. Papers on asylum seekers and undocumented migrants were excluded.	Data on utilisation of primary care services was mixed with around half the studies showing higher utilisation and half showing lower utilisation. All but one study showed significantly lower uptake of screening services. However, uptake of hospital and A&E services tended to be higher.	Limited health literacy; lack of knowledge about service availability; poor accommodation for cultural differences; lack of health insurance; language barriers; socioeconomic barriers.

Table 1: Barriers to accessing care for migrants adapted from O'Donnell et al 2016

There is clear evidence of limited engagement in preventive healthcare by migrants (Beune et al 2011:74). Many of the reasons for this may be similar to general barriers to access, such as the limited information provided to migrants, unsatisfactory language provision and the fact that migrants often have many competing priorities (Sheikh & MacIntyre 2009: 402). Prevention requires an additional level of engagement however, since individuals are not ill at the point at which they interact with services or practices. It also requires a shared understanding of what it means to be healthy, and what constitutes risk behaviours (Beune et al 2011:74). Bader et al, exploring the lack of uptake of CVD prevention amongst Turkish immigrants in Germany suggested a combination of lack of information with 'language and other cultural barriers' were responsible (2006:218). Similarly, Patel et al's assessment of barriers to uptake of CVD prevention amongst South Asians in the US emphasised the cultural aspects including 'misconceptions, cultural priorities, cultural identity, and explanatory models of disease' (2012:774). Henderson et al, in a paper on prevention for culturally and linguistically diverse (CALD) communities turn the responsibility back towards service providers, however, suggesting that it is they who do not know how to provide culturally appropriate services (2011:225).

Access to appropriate health information for ASRs and other migrants can be a barrier to accessing care effectively (Jayaweera 2010:81). Jayaweera, in a review of migrant health literature suggested that there is concern in the UK about inadequate provision of information both regarding what services are available, such as screening and preventive services, and also on how to use services appropriately, for example information booking systems, opening hours, and when to use which service (ibid). O'Donnell et al's qualitative research in Glasgow corroborated this – ASRs had limited awareness of health promotion or screening opportunities, nor were they clear on the most appropriate ways to seek care (O'Donnell et al 2007:81-2).

O'Donnell et al 2007 interviewed asylum seekers about their perceptions around access to healthcare in Glasgow. While all participants were registered with GP practices, and were generally satisfied, tensions occurred around the mismatching of expectations (in particular understandings about the extent to which GPs were knowledgeable about the range of conditions and symptoms they encountered), lack of awareness about when to seek GP care, or how booking systems work, and dissatisfaction with interpreting services (O'Donnell et al 2007:75-82).

O'Donnell et al's finding that levels of GP registration are high amongst refugees and asylum seekers in Glasgow is corroborated by studies in the grey literature. A longitudinal study by Mulvey (2013) for the Scottish Refugee Council which examined ASR experiences related to integration, noted that 96% of ASR respondents were registered with a GP (Mulvey 2013: 9). A study for NHS GGC found a similar picture (Roshan 2005:11). However, evidence from other parts of the UK suggests a different picture. A cohort study of new entrants to the UK screened at Heathrow and Gatwick airports found that the asylum seekers within the population were less likely to register with a GP once in the country (Stagg et al 2012). Similarly, Bhatia & Wallace's study of refugees at a walk-in clinic in London suggested that asylum seekers struggled to find out how to register with GP services (Bhatia & Wallace 2007). This may suggest that the system of facilitating GP registration for new arrivals to Glasgow is effective in ensuring high levels of registration.

As noted by O'Donnell et al, however, barriers to optimal service use do exist despite high levels of registration. Roshan 2005 also noted similar concerns amongst ASRs in Glasgow – barriers related to language, lack of clarity on GP booking processes and, additionally, concerns around the attitudes of health professionals (Roshan 2005: 11). These were all barriers identified in the international literature (Table 1). Research by the Glasgow Centre

for Population Health on access needs in the South East of Glasgow again noted a significant barrier related to navigation of the GP system, an issue that was felt both by providers of services, and ASRs using the service (GCPH 2008:6).

Mismatching of expectations has an impact both on ASRs and service providers, since it can lead to ASRs being dissatisfied with the care that they receive and health professionals feeling that ASRs don't fully appreciate or understand the NHS. O'Donnell et al suggested that for some ASRs differences in expectations reflected previous healthcare experiences, such as being able to access specialists directly, or buy antibiotics without a prescription (O'Donnell et al 2007:79; O'Donnell et al 2008:e2). Being presented with 'non-specialist' GPs was therefore considered a disappointment (Cooper et al 2012:599; O'Donnell et al 2008:e7). This lack of 'fit' between expectations and practice was also reported by Lindenmeyer in a qualitative study of primary care staff in Birmingham (Lindenmeyer et al 2016b). One area where this often becomes apparent is in prescribing, where migrant patients (including ASRs) hope for antibiotics but instead are offered advice or paracetamol (O'Donnell et al 2007:8; Lindenmeyer et al 2016a:3; Madden et al 2017:6).

Given the evidence that ASRs do not/ are not able to make optimal use of health services and because entitlement to care does not mean that all individuals will use it equally, it is useful to explore in more depth some of the factors that are suggested to impact on access to care, both from the supply side and also the demand side. Kovandzic et al, in their study of access to mental healthcare for Somali immigrants in Liverpool, note the complex dynamics at play, suggesting that it is necessary to consider a 'range of related issues – from how common mental illness is conceptualised to how services are configured and how personal and others' experiences of available treatment influence future help-seeking activities' (2012:537). To fully address all these factors, they suggested the concept of the 'space of access' which would explore all the interrelating aspects that impact on access in context (ibid:540-546). The research in this thesis is intended to draw a fuller picture of this 'space of access' by drawing together theories at the micro-, meso-, and macro-level. These theoretical approaches will be discussed in Chapter Three.

Beyond micro-level engagements, a relevant factor when considering ASR access to healthcare is the political context in which care is sought or offered. This political context has an impact both on what entitlements exist, and whether those entitlements can be realised.

2.3.3 Problematising entitlement

Around the world, migrant entitlements to healthcare vary greatly (Fleischman et al 2015: 90). This variation exists both across countries, and within countries across migrant groups (Simonnot et al 2016:10-11; fra.europa.eu¹²). Policy shifts and retractions, for example in terms of who is eligible to access care, also create difficulties and confusion with respect to entitlement, both for ASR patients and for healthcare professionals (O'Donnell et al 2016).

As noted in the introduction, entitlement to healthcare for ASRs differs slightly between Scotland and England. While ASRs, including those who have had their asylum claim rejected, are entitled to primary care in England, Scotland and Wales, only in Scotland and Wales are refused asylum seekers entitled to secondary care (gov.uk/guidance/nhs-entitlements-migrant-health-guide). Numerous rule changes have complicated this, meaning that health service professionals are often unclear as to what their obligations are (Reeves et al 2006:307; Keith & van Ginneken 2015:2). While ASRs may enjoy entitlements to healthcare in the UK that they do not have elsewhere, entitlement to care does not necessarily equate to physical access, and as discussed in Section 2.3.2, there are many barriers that impact on ASR health service use (Chauvin et al 2012; Davrin et al 2012). Indeed, Koehn 2009 notes that access is not merely about the technicalities associated with entitlement, but the notions and perceptions about particular groups that accompany them (2009:587).

When a country's prevailing attitudes to immigration are negative, the extent to which entitlement to care can be capitalised on is diminished. Larchanché notes the paradox in France, whereby undocumented immigrants are entitled to access healthcare, while at the same time are constructed as a group that is illegitimate (Larchanché 2012:858). By stigmatising immigrants and forcing them to live in fear and in precarious conditions, national policies and rhetoric severely limit their capacity to access healthcare (ibid:859). In San Francisco, a concerted effort has been made to ensure that undocumented immigrants are able to access the healthcare that they are entitled to by law (Marrow 2012: 846). Many healthcare services are set up to facilitate this, staffed by service providers who are committed to the notion that undocumented migrants are deserving of care (ibid). This commitment is insufficient, however, to entirely diminish the impact of broader anti-immigration policies, which serve to spread fear among immigrants and lessen the likelihood that they will engage with services (Marrow 2012: 847). An important caveat,

¹² Full ref: <http://fra.europa.eu/en/theme/asylum-migration-borders/healthcare-entitlements>

however, as Marrow notes, relates to the impact that rhetoric and policy can have for positive outcomes as well as negative ones. She suggests that in San Francisco a culture has been created whereby voices that constructed immigrants as undeserving have been silenced, and the overriding sentiment is one where they are entitled to support (Marrow 2012: 846).

A report by the Glasgow Centre for Population Health on ASR healthcare access highlighted a similar issue, which was the effect that the position of being an asylum seeker had on access to care not just in terms of presenting a physical barrier, but also a symbolic one. Asylum seekers in Glasgow had begun to internalise the low status they were ascribed by the media, and sometimes also the communities they were part of, and had lowered their expectations about what they were entitled to accordingly (GCPH 2008:6). Processes of exclusion such as this had an impact not only on access to care, but also on ASRs' broader feelings about their health.

Healthcare (and other) professionals' attitudes towards ASRs may additionally undermine entitlement to care for those who do seek it out, if those professionals do not consider ASRs to be entitled to, or deserving of, treatment. In France, undocumented immigrants are routinely refused care even though they have a right to it, which Larchanché suggests is reflective of an overarching attitude that suggests these immigrants are undeserving (2012:860). Chase et al used the theoretical concept of candidacy¹³ to explore the 'health seeking trajectories' of asylum seekers in Canada who they suspected under-utilised health services despite being entitled to care. While noting the variety of ways in which asylum seekers' undecided migration statuses impacted on their ability to assert their right to healthcare (2017: 57), Chase et al mentioned in particular the role of professionals in undermining entitlement. Although asylum seekers were made aware of their entitlement on arrival in Canada, many were subsequently told by professionals that they could not access care. Not only did this prevent ASRs from obtaining services in that particular instance, but they were also less likely to assert their right to care on future occasions since they had lost faith in the legitimacy of this entitlement and readjusted their expectations (Chase et al 2017:54-6).

In the UK there has, for a number of years, been concern about calls requiring health professionals to report the immigration statuses of their patients to the UK Home Office

¹³ The theory of candidacy (Dixon-Woods 2005) provides a theoretical framework for this thesis and is discussed in detail in the following chapter.

(Moberly 2017). This concern was heightened in Jan 2017 when a memorandum of understanding was signed between the Department of Health, the Home Office, and NHS Digital to facilitate the sharing of non-clinical patient data (Doctors of the World & Just Fair 2017:1). NGOs have, in response, called on health professionals not to reveal patients' immigration statuses (doctorsoftheworld.org.uk/news). This is not a new phenomenon however, with the BMA already having passed a motion in 2005 underscoring the same point (Reeves et al 2006:307). Given the body of evidence that fear related to immigration status is a critical barrier to access to care, putting ASRs at significant risk (Doctors of the World & Just Fair 2017), this development brings into sharp tension the relationships between entitlement and access.

2.3.4 Focus on preventive care

As noted previously, whilst a good deal of the literature on access to primary care looks at the experience of migrants, research on access to preventive care in the UK and Europe has traditionally focused on ethnic minorities. Indeed, Netto notes that while much has been suggested about the reasons why migrants may have poorer health, there has been little examination of 'the alterable causes of health-related knowledge, behaviour and attitudes, and the effectiveness of health promotion, educational initiatives and preventative services in countering these causes' (Netto 2012:257). While Bhopal emphasises the commonalities between migrant and ethnic minority experiences that might facilitate similar approaches (2012:26), there are aspects of being a migrant that require foregrounding. In the case of ASRs, as some of the most vulnerable and disadvantaged strata of society, it is critical that those designing health promotion and preventive interventions specifically take into account their needs as regards preventive care (Kallayova & Maidan 2012:287).

Given the particular concern around high rates of diabetes and CVD amongst South Asians (Patel et al 2012:274), and the traditional focus on ethnicity rather than migrant groups, it is unsurprising that the majority of targeted interventions in the UK are directed towards those of South Asian ethnicity (Netto et al 2010:254). CHD interventions directed towards other groups have been fairly limited (ibid:265).

It is important to note that while lifestyle interventions are often considered to be an effective means of behaviour change for the general population (Nicolau et al 2013:1), there is still much that is unknown in the literature on health interventions in general, and many differing opinions about the optimal methods for health promotion (Netto 2012:257).

2.3.4.1 What makes a targeted intervention?

With the assumption that prevention interventions require adapting to meet the needs of migrant groups, a small body of literature has considered what aspects require targeting. Netto 2012 has developed a number of best practice points for the development of interventions for migrants. These are summarised in Table 2:

Best practice	Commentary
‘Use community resources to increase accessibility’	Engaging community resources such as community leaders or community media can help increase awareness and encourage ‘buy-in’
‘Identify and address barriers to access and participation in interventions’	This might include gender issues such as not wishing to use same-sex sports facilities, or socioeconomic issues such as inability to afford public transport
‘Develop communication strategies which address language use and differential information requirements’	This extends beyond providing information in different languages and should involve accommodating varying levels of literacy and preferences for different communication styles
‘Identify and work with cultural or religious values that either motivate or inhibit behavioural change’	This involves challenging cultural values that may hinder behaviour change and emphasising those that may assist it
‘Accommodate degrees of ethnic/cultural affiliation in the planning and evaluation of targeted interventions’	Acknowledging that individuals from the same ‘community’ will identify with cultural norms to varying degrees

Table 2: Best practice for targeted interventions from Netto 2012:262-265

It is also important to address structural and contextual issues when developing interventions with ‘at-risk’ groups (Kallayova & Maidan 2012:295; Netto et al 2010:249). However, perhaps because of the associated challenges, researchers often tend to mention this in passing rather than integrating it into their research or intervention development (Castaneda et al 2015:379). Palinkas et al, describing the various stages required for refugee health promotion suggest that the main issue at play is ensuring that the intervention is culturally relevant, which they suggest could address ‘a lack of understanding’ of the purposes of prevention on the part of refugees. However, they then explored only the cognitive barriers to behavioural change rather than any structural ones (2003:22). As described in the following section, this focus on culture can have problematic consequences.

A final aspect considered to be integral to successful health promotion with migrant communities is the active involvement of those communities in the development of interventions. Kallayova & Maidan report on a five-year project, the 'Healthy Inclusion Project' which intended to encourage migrant participation in health promotion in eight EU countries. (2012:287). They emphasised that focusing on the broader context of the migrants' lives that were the target of interventions was critical (ibid:295).

2.3.5 Culture and health

Culture is a pervasive theme in the literature on access to primary and preventive care, as well as the literature on perceptions of health. In particular, there is literature that focuses on how culture i) shapes health beliefs, ii) impacts on engagement with care, and iii) can be leveraged to improve service provision (Sargent & Larchanché 2011: 354; Viruell-Fuentes 2009). I explored in the introduction some of the tensions around the definition of the term 'culture', all of which are relevant in terms of its application to healthcare. It is important to remember that although culture is constructed and fluid (Durieux-Paillard 2011: 204), and there is much to critique in the ways that it is used in the health system, it still carries with it real meaning and impacts on the ways that individuals understand themselves and others.

Unsurprisingly, given that it is a contested concept, the term culture is used inconsistently throughout the literature on migrant health¹⁴. This raises questions about the assumptions underpinning it, and the resulting implications for service provision. Across the literature from public health and health services research, there is broad consensus that services provided for migrants should be 'culturally competent' (e.g., Cristancho et al 2008:638; Norredam & Krasnik 2011:73) such that the culture of the patient should be recognised and accommodated. Culturally competent approaches have been extremely important in increasing professional sensitivity and helping to ensure that services and interventions are appropriately targeted. However, it is rare for questions about the meaning of culture, and cultural competence, to be considered in significant depth and there are many potential pitfalls to this approach that need to be addressed. In particular, culturally competent approaches have been criticised for i) suggesting that poor health and/or barriers to access are the fault of a patient's culture, ii) assuming it is only the patient who has a culture when in fact all individuals and institutions have a culture, and iii) conceiving of culture in an

¹⁴ see introduction for a discussion on definitions

overly reductive and static manner (Holmes 201:873; Napier et al 2014;1607; Viruell-Fuentes 2012: 2100).

Power imbalances can also be cemented through the way that culture is defined in healthcare, since it is those on the provision side that determine what culture is, and who is culturally “different” (Thurston & Vissandjee 2005:233). Hendriks et al, in a study of dietary behaviour amongst Surinamese immigrants of Indian descent in the Netherlands, discuss ‘Indian culture’ as a homogenous entity and suggest that because it is a collective rather than an individualistic culture, individuals are less likely to be able to change their behaviour than those from a ‘Western’ background (2012:20). This puts Indian culture in direct conflict with western norms, suggesting that Surinamese culture is in some way ‘other’. Koehn notes that these sorts of over generalised descriptions of the behaviour of certain groups serve to develop a mentality where there is a divide between ‘us’ and ‘them’ (Koehn 2008:587). While it is rare to see critiques of the culture of the society in which migrants live, as well as the culture of the immigrants (Viruell-Fuentes 2012: 2100), there is research that takes a more nuanced approach. Kampf & Goksu, researching perceptions of CVD risk and prevention strategies amongst Turkish migrants in Germany take a different approach. While culture (broadly conceived) is a significant focus of analysis, they warn against creating a dichotomy between exotic cultural explanations and more prosaic non-cultural ones. They argue that this distinction is constructed and that there are often similarities in the ways that migrant and majority populations talk about their health (Kampf & Goksu 2013). Such dichotomies are problematic in the way that they exoticise ‘other’ cultures, while making invisible dominant cultures.

An additional way in which the use of the term culture can subtly invoke blame is through the use of the term ‘cultural barriers’. This term is often used when talking about health service use, or engagement with preventive care (Cristancho 2008:634). The phrase suggests that access and engagement issues are problems of culture, and, perhaps inadvertently, places blame onto the individual or the culture they belong to. It also creates a barrier between the migrant who has a culture and the service provider who – allegedly - does not. Farooqi et al, in a qualitative study of attitude towards lifestyle risk factors for CHD amongst South Asians in Leicester, were careful to emphasise that South Asian culture was not homogenous (Farooqi et al 2000). There was, however, no recognition that all attitudes to risk factors (not just South Asians’ attitudes) are culturally influenced. Additionally, culture was considered to be a barrier to lifestyle change, which subtly suggests that it is the culture that is to blame for ‘unhealthy’ behaviours. Penn et al

similarly positioned culture as a barrier in their qualitative study of UK Pakistani women's attitudes to a culturally adapted Type 2 Diabetes Mellitus preventive intervention (2014:2).

There is concern that in research on migrant and ethnic minority health, too great an emphasis can be placed on cultural explanations for occurrences at the expense of structural or socioeconomic explanations (Durieux-Paillard 2011:209; DeGraaf et al 2012:378-90; Viruell-Fuentes 2012: 2100). Dastjerdi et al, for example, write about the reasons for which Iranian immigrants (not necessarily ASRs) make limited use of services, suggesting that it is because of the 'collectiveness valued in their culture' which means they put others before themselves (Dastjerdi et al 2012:58). Rather than consider this as something specific to Iranian culture, it is useful to think about the very concrete reasons that an individual might put their own health needs behind other priorities, such as finding secure housing, or finding schools for their children. A more helpful approach would be to examine 'how culture intersects with other structures such as race, class and gender, to influence people's perspectives and engagement' (Viruell-Fuentes 2012: 2100). This way the assumption that it is only culture that constrains health could be challenged (Thurston & Visandjee 2005:232-233).

An important way in which culture has been conceived in terms of its impact on understandings of health and engagement with health practices is through Kleinman's concept of explanatory models (EMs) (Kleinman 1988). Ton et al examined knowledge of cardiovascular health amongst Chinese, Korean and Vietnamese immigrants in the USA. Using an explanatory models approach they explored the 'non-western' norms that were considered to impact on perceptions of disease causation (Ton et al 2011:137). This is a useful starting point in terms of understanding what health means to individuals. However, Ton et al contrast these 'cultural' perceptions with the western biomedical model, suggesting that the two were mutually exclusive. In doing this, the cultural explanation becomes unnecessarily exoticised. Ton et al described perceived links between anxiety and heart disease as culturally determined (2011:137), yet there are likely many people who ascribe to a 'western' model that would make this link as well. Arcury et al 2004 similarly sought to elicit explanatory models of Latino immigrants in North Carolina with regard to diabetes. Following Kleinman, they suggest that "those sharing a culture have their own explanatory model of illness that influences their behaviours with regard to prevention and treatment and which differ from biomedical models" (Arcury et al 2004:2184). The descriptions of Latino EMs offered are quite prosaic however: they concluded that participants were not entirely clear about diabetes causal factors but focused on a

combination of behavioural and genetic factors (ibid: 2188). It is unclear whether it is useful to consider these EMs as culturally specific since it is likely that individuals across many cultures (including white, western ones) would offer a similar account. Kleinman himself warns against an uncritical understanding of these models as it can have the very effect that he was trying to mitigate against, which is assuming that each culture can be considered as a set of 'tick-box' stereotypes (Kleinman & Benson 2006: 1675).

Where public health research engages with theoretical models of culture there is greater potential for a more nuanced approach, even if, as described above, this is not always the case. Culture can be considered at several different levels. Netto et al 2007 and Nicolaou draw on Renisow's concepts of 'deep' and 'surface' level culture in exploring the different levels at which a culturally competent intervention needs to work. Where surface level culture includes issues such as dietary habits, deep level culture relates to more pervasive mechanisms such as gender norms (Netto et al 2007; Nicolaou 2013). It is suggested that both have an impact on an individual's willingness to engage in preventive behaviour and so effective interventions must address both levels (ibid). In this reading culture can tie into structural issues, which facilitates exploring cultural traits in a way that does not give sole responsibility to individual cultures over the structural context. Wei Yeoh & Furler, in a study on diabetes perceptions amongst South Sudanese immigrants in Melbourne draw on Bandura's concept of culture which takes into account the 'socio-historical circumstances' in which culture is both formed and expressed (2011:914). It is suggested that this is helpful in ensuring that stereotyped understandings of a community are avoided. However, even there it is easy to rely on notions of a homogenous culture, and Wei Yeoh & Furler revert to uncritical usage of the term community (ibid). More nuanced approaches are helpful in ensuring that while culture is a focus of analysis (although it is constructed it still has real meaning for individuals) it is not used in a way that is a-contextual, or ignores the other factors with which culture interacts. This is still a rare approach in work that draws on issues of culture (Zhou et al 2016:1067).

There is increasing recognition, however, that a more critical approach to culturally competent healthcare provision needs to be taken. The fact that culture might mean different things to different people is noted (Mezzich et al 2009:384) and Renschler and Cattacin suggest a focus on social context rather than culture as a solution to an overemphasis on cultural traits (2007). This is a relevant consideration in the work presented here, where ASRs – even from one broad geographical area – will encompass different cultural groups.

2.3.6 Language

Related to questions about culture and cultural competence, a key focal point of the literature is language and communication issues in service provision. There is a very large literature specifically on interpretation in healthcare which will not be addressed in detail here. It is critical to underscore the significance of this body of research, however, since poor communication in healthcare consultations has been demonstrated to impact negatively on patient care (Derose et al 2007:1260). Not only are individuals less likely to visit healthcare providers in the first place, but when they do, there is a much greater chance of mutual misunderstanding. This can result in non-compliance with treatment protocols (Van Wieringen et al 2002: 65), and increase the risk of misdiagnosis (Karliner et al 2007:743).

Professional interpreters can play a role in surmounting some of these obstacles, preventing errors in communication, ensuring that patients have a better understanding of the consultation, and thus improving patient satisfaction (Flores et al 2005; Karliner et al 2007). Availability of interpreters is often not sufficient to cover need however, meaning that non-professional interpreters such as family or friends often take on this role. In these informal interpreting situations, communication errors are likely and patients are less likely to be satisfied (Gill et al 2011; Flores et al 2005:278). Additionally, there is concern that interpreters may not translate everything the patient is saying, and/ or patients may feel uncomfortable talking about sensitive issues in the presence of their family member or friend (Duncan et al 2010: 138; MacFarlane et al 2009:212).

In the broader literature on ASR access to care there is acknowledgement that good communication is about considerably more than translation between different languages, and is influenced by the perceptions and approaches of both service providers and service users (Norredam & Krasnik 2011:72). Therefore, whilst the presence of interpreters is crucial when providing health services to individuals who do not speak the majority language, it does not guarantee that there will be good communication between service users and providers. Whilst some stress that translation cannot prevent against misunderstandings caused by cultural differences (Durieux-Paillard 2011:206), others state that language is a considerably larger barrier than culture and therefore the significance of culture should not be overemphasised (Priebe et al 2011:196). Also raised in the literature, are difficulties arising from the interpreters often having unclear roles (O'Donnell et al 2007) and the often blurred boundaries between acting as an advocate for a patient and

simply helping to facilitate communication. As with discussions around cultural competence, problematic assumptions can also be made about the differences between different groups of individuals, and there is often a lack of consideration of other issues such as gender.

2.3.7 Non-health priorities

Though often overlooked, or only briefly alluded to by much of the literature, one of the most significant factors affecting access to care is the context in which services are offered or sought (Joshi et al 2013:88). ASRs are subject to a large number of priorities and pressure which mean that attending to health and accessing healthcare may not be a major priority (Aung et al 2010:295). These may include issues related to poverty, discrimination, and the uncertainty that accompanies waiting for refugee status (Jones & Gill 1998:1444; Viruell-Fuentes 2012:2099). It is striking that so much of the literature on access to care, and perhaps even more so on preventive care only alludes to this context in passing, or as an afterthought rather than exploring the ways in which it is intimately connected with engagement (Viruell-Fuentes 2012: 2099). Additionally, and as previously discussed, culture is often used as an explanation where contextual explanations might be more appropriate.

2.3.8 Professional perceptions

A critical element of access to care, particularly in the case of vulnerable or marginalised individuals, is the perceptions and behaviours of healthcare professionals, who must be negotiated with in the process of securing access to care. Despite the importance of their role, it is relatively uncommon for studies to focus on the perceptions of health professionals (Priebe et al 2011:187).

Holmes notes that medical students in the US are taught about health from a biomedical and behavioural standpoint, and are therefore ill-placed to contextualise the health experiences of their patients (2006:1790). This can result in patients being blamed for their health outcomes when the cause may in fact be external (ibid). In the case of migrant and ethnic minority patients, these 'behaviours' might be attributed to cultural differences. Abbot & Riga looked at the experiences of primary care professionals treating Bangladeshi in Tower Hamlets, London. Many of the respondents spoke about patients'

negative behaviours, such as failing to attend clinics, or making appointments for insignificant issues and suggested that Bangladeshis were unaware of how to use services appropriately (2007:937). The professionals then attributed these issues to cultural norms. Importantly this was considered to be a community-wide issue, rather than a problem of just some individuals and thus an entire culture was considered at fault (Ibid:938).

While tendencies towards blame are not uncommon amongst health professionals, there is also awareness that ASRs have specific needs that they might not be sufficiently equipped to address. Health professionals can therefore feel paralysed to assist their ASR patients. Holmes in his work on the health of Triqui Indian farm workers in California suggests that medical professionals feel they do not have the tools to address the structural determinants of their patients' health, and thus focus only on individual issues (2012:877). In the UK, Kovandzic et al noted similar tendencies amongst health professionals in Liverpool – the needs of their Somali patients were so overwhelming that it became easier to focus on a medical model of health that located illness within the individual's biology and behaviour (2012:544). This may also explain why the professionals in Abott & Riga's study did not consider the impact of poverty, race or migration, but focused at the individual level.

Moves towards cultural competence may have unintended effects on health professionals. By prefacing culture, they may be led to see ASRs (as well as other migrants and ethnic minority groups) as an 'other' and as noted above, prioritise the cultural explanation above more prosaic ones. Health professionals may also take a detached approach due to concerns that their actions will be considered racist or ignorant (Kai et al 2007:1677). Kai et al in a study of health professionals' attitudes towards cultural competence noted that professionals were reluctant to take a proactive approach, lest their efforts resulted in them stereotyping their patients (ibid).

Begg & Gill 2005, Roshan 2005, and the GCPH 2008 also note the role of service providers in influencing the care process. ASRs in Roshan's study suggested that health professionals didn't sufficiently understand their needs (Roshan 2005:19). Both Begg & Gill and the GCPH study asked health professionals themselves, who concurred that they had insufficient training to adequately assist ASRs, particularly in relation to their non-medical needs (Begg & Gill 2005: 303; GCPH 2006:7). Lack of knowledge about the needs of ASRs may trap healthcare professionals either into taking less care than they might have otherwise, or into relying on overly reductive stereotypes.

2.4 Situating ASRs from Sub Saharan African in Glasgow

2.4.1 ASR health and wellbeing in the UK

As well as barriers to access to primary and preventive services, there is evidence that those not born in the UK experience poorer physical and mental health than those born in the UK (Jayaweera 2014:2).

Quinn discussed the impact on health caused by experiences before migration, during migration and once individuals are ‘settled’ in the UK (Quinn 2014:59). The notion that three separate phases of migration can affect ASR health has also been highlighted by Zimmerman (2011). She argues that it is important to examine how each of these stages contribute to overall health. While the impact of the origin country is often considered (particularly in terms of mental health), the receiving environment also has a significant influence on ASR wellbeing (Kearns et al 2017).

A striking feature of the research on ASR health in Glasgow is that it indicates that health appears to worsen the longer an individual remains in Glasgow as an asylum seeker. Mulvey notes that a ‘significant’ minority of ASR respondents in a longitudinal study considered their health to deteriorate the longer they remained in Scotland. While for some this related to diagnosed health conditions, for many it was due to their inability to establish a settled life in the UK (Mulvey 2013:8). Strang and Quinn (2014), in a report for the Scottish Refugee Council, similarly noted that refugees and asylum seekers perceived the most significant threats to their wellbeing to be related to living in challenging circumstances: in poverty, with uncertain migration statuses, and with limited social connections (Strang & Quinn 2014:6). Declining health is often experienced as declining mental health. Zimmerman et al, in a study of refugee women’s exposure to violence in Scotland, noted that 54% of the women surveyed felt they had poorer mental health now than before they arrived in Scotland (Zimmerman et al 2009:17).

The notion that the longer one remains an asylum seeker the poorer one’s health becomes is supported by epidemiological evidence from Glasgow. Kearns et al used data from the Go Well¹⁵ study to explore whether the healthy migrant effect¹⁶ held for ASRs in

¹⁵ Go Well was a ten-year longitudinal research programme launched in Glasgow in 2005 with the aim of ‘investigating the impacts of investment in housing and neighbourhood regeneration in Glasgow on the health and wellbeing of individuals, families and communities’ (gowellonline.com)

Glasgow, many of whom live in highly deprived areas of the city (Kearns et al 2017). While they determined that the health of refugees tended to be better than that of the communities in which they lived, the same was not the case for asylum seekers. The health of the asylum seekers in the sample deteriorated the longer they waited on asylum claims and this disadvantage remained even after receipt of refugee status (Kearns et al 2017). Numerous potential explanations were drawn upon to explain this, such as the way in which asylum seekers are automatically deemed untrustworthy, or the barriers created by enforced poverty.

While this finding is reflected in much of the grey literature research, there has been limited in-depth research into the ways individual experiences of the asylum system impact upon and shape health and access to care or the potential for future successful engagement.

Gender plays an important role in shaping the health-related experiences of refugees and asylum seekers. Zimmerman et al 2009 noted that asylum seeking women in Glasgow have experienced particularly high rates of physical and sexual violence, both by intimate partners and others (Zimmerman et al 2009: 21). While women face specific vulnerabilities that men do not, there has also been concern in Glasgow that young single men, who make up the largest proportion of asylum seekers in the city are also the most isolated and least likely to access services (Strang 2015:7).

2.4.2 Statutory responses to refugees and asylum seekers

Since Glasgow became an asylum dispersal city in 1999, both research and practical provision for ASRs has increased exponentially. This includes literature related to health and wellbeing, but spans a broader range as well. The Scottish Government noted in its ‘New Scots’ Strategy that it had invested over £13.5 million in ASR integration up until 2013 (Scottish Government 2013: 23), and the investment in ASR integration is continuing as the strategy moves forward (Scottish Government 2017). There has additionally been a significant, voiced commitment from NHS GGC to ‘promoting inclusion and equality’ as regards ASR health and wellbeing (Strang 2015: 5) and this has been included in the Scottish Executive’s Scottish Refugee Integration Forum action plan (Roshan 2005:15). A

¹⁶ The healthy migrant effect refers to the notion that migrants are often healthier than the population of their host country. This health advantage is often seen to diminish until the health of the migrant group and that of the host country population converge (Kearns et al 2017:675)

number of projects have been developed in conjunction with public sector agencies in order to realise this commitment.

A prime example of statutory and third sector collaboration is the Holistic Integration Service which was developed in partnership with third sector organisations and higher education institutions and offered tailored support to refugees in the 12 months following receipt of status (Strang et al 2016:5). Though focused on integration in its broadest sense, concepts of health and integration are closely linked, since successful integration leads to a sense of wellbeing which may impact on individuals' perceptions of how healthy they are (Strang & Quinn 2014:7).

There have also been projects that have focused squarely on health, such as the Refugee Peer Education Project which ran from 2014-2015 (Strang 2015). This project, spearheaded by NHS GGC, trained refugees to act as peer health educators. There was particular attention paid to the needs of men who are considered to be amongst the most isolated (Strang 2015:7). Other research on refugees and asylum seekers in Glasgow has centred on the theme of 'integration' (e.g., Strang & Quinn 2014).

2.4.2.1 Access to primary care

All ASRs in Scotland are entitled to healthcare¹⁷ (Roshan 2005:15) and since 2013, asylum seekers' first encounter with primary care services in Glasgow has been through the Asylum Health Bridging Team (AHBT)¹⁸ a dedicated service which provides initial screening for all newly arrived asylum seekers and allocates them a GP practice (<http://www.nhsggc.org.uk>; <http://www.migrationscotland.org.uk/>).

While the Scottish Government has expressed a strong commitment to facilitating integration of ASRs and providing equitable access to care (Scottish Government 2013; Scottish Government 2017), the situation at UK level is different, however, and this impacts on the health and wellbeing experiences of those in Glasgow (Mulvey 2015). Changes to the rules regarding asylum support (directed from the UK Home Office) has led to a concern amongst professionals that increasing numbers of asylum seekers in

¹⁷ Destitute asylum seekers are entitled to free secondary care in Scotland, Wales & Northern Ireland, though not in England (Worthington 2017:2).

¹⁸ The AHBT was initially based at the initial asylum accommodation centre and was therefore able to assess almost all arrivals in Glasgow. Since asylum accommodation has been privatised the team has been moved and there is a greater challenge in finding and assessing asylum seekers who are dispersed throughout the city.

Glasgow are becoming destitute, with the Red Cross in Glasgow seeing three times as many destitute clients in 2016 compared with 2013 (Burka et al 2017).

2.4.3 Sub Saharan Africans in Glasgow

The number of individuals identifying as 'Black' or 'Black African' in Glasgow has increased considerably, as the city has become more ethnically diverse and they are a very new migrant population in Glasgow. While the 2001 census indicated that there were 5000 individuals of Black or Black African ethnicity in Scotland, this had increased to 30,000 by the 2011 census (Simpson 2014:1). African migrants come to Scotland for a variety of reasons, and make up a significant proportion of the ASR population (Cooper et al 2012). There is very limited data on the health of Africans in Scotland, in part due to the fact that until recently, they comprised such a small proportion of the Scottish population. The Scottish Health and Ethnicity Linkage study which sought to examine a variety of health outcomes by ethnicity, used ethnicity data from the 2001 census when there were only 5000 people in Scotland identifying as 'African' (Simpson 2014:1). Data from this project exploring myocardial infarction (MI) incidence by ethnic group showed that black and African men experienced similar rates of MI to white Scottish men, a group known to have a particularly high prevalence of MI (Bansal et al 2013). Another study that sought to link ethnicity to mortality rates was unable to include people of black or African ethnicity as there were too few to be statistically significant (Gruer et al 2016).

The most recent census data related to health does suggest that Africans enjoy some advantage over the majority white Scottish population. Age-standardised data on self-rated health by ethnicity in Scotland (based on the 2011 census questions) suggests that those of black or African ethnicity have, as a whole, better health than the majority white Scottish population, as do most other ethnic groups (Scottish Government 2015). Three points are relevant here, however. Firstly, these data report on self-rated health, rather than actual health outcomes; second, it does not distinguish between refugees, asylum seekers, and other types of migrants; and third, the health of the majority white Scottish population is also markedly poor and therefore not necessarily a useful baseline.

Despite limited data from Scotland, there is, however, sporadic evidence on health inequalities experienced by SSA migrants in the UK and Europe more broadly. Jayaweera, for example, in a briefing on the health of migrants in the UK notes that black African mothers had the highest rates of maternal mortality (four times that of white British

mothers) in the Confidential Enquiry into Maternal Deaths (Jayaweera 2014:5) Although research on SSA migrant health (and indeed the health of people living in Sub Saharan Africa itself) has focused largely on infectious diseases, in particular HIV/AIDS, there is, across Europe, a growing interest in non-communicable disease risk. This includes concerns about the increasing incidence of chronic conditions including diabetes and hypertension among SSA migrants (Cooper et al 2012:598). Not only may they be at higher risk than other populations in Europe, but they may also be at higher risk than populations in their home countries. The EU funded RODAM study (rod-am.eu) examined rates of obesity and type II diabetes (T2DM) amongst Ghanaians in rural and urban Ghana, the Netherlands, Germany and the UK. In addition to identifying higher prevalence of obesity and T2DM amongst urban Ghanaians compared with rural Ghanaians, they also identified significantly higher prevalence of both conditions amongst those Ghanaians who migrated to Europe, compared to those who remained in rural Ghana (Agyemang et al 2016). Other research suggests that West African migrants may have a higher risk of stroke (Kunst et al 2011:105). Given the size of the continent and variations in individuals' backgrounds and experiences, the strength of these risks may vary considerably between countries and different ethnic groups.

Given the growing burden of chronic disease in Africa and amongst SSA migrants in the UK, there is concern about how migrants coming from a different medical culture might interpret that risk. Cooper et al examined the lay perceptions of SSA migrants in Glasgow (many of whom were ASRs). Amongst the participants there was limited awareness of chronic diseases such as diabetes or CVD, and a tendency to use infectious disease framing when talking about health (Cooper et al 2012:608). These findings have implications for health promotion programmes which need to engage with individuals own understandings of health. However, although ASRs made up a large sample of the research participants in this study, only limited reference was made to the structural factors that might impact on lay beliefs of, or approaches to, chronic disease risk.

The main focus of health promotion directed towards SSA communities in Scotland tends towards HIV prevention. The African Health Project which is run through the HIV charity Waverley Care, and commissioned by NHS GGC, delivers HIV prevention education and works with HIV positive Africans (DaCosta Lima et al 2016:3). Additionally, a recent PhD thesis examined perceptions of individuals from Sub Saharan Africa in Glasgow in relation to targeted HIV prevention initiatives (Smith 2016). There are however a number of organisations working more broadly to promote wellbeing, such as AfricAlba

(Africa.alba.org), a charity that aim to promote social and economic inclusion of Africans in Scotland.

Research on ASRs in Scotland suggests that the asylum system, along with other structural factors, affects ASR health and wellbeing negatively. However, there has been no research to explore the mechanisms by which this may occur and especially not amongst ASRs from Sub Saharan Africa who exist at the intersection of a multitude of vulnerabilities. There has also been no research in Scotland on the ways in which these factors affect capacity to engage in preventive care, through impacts on access to care and perceptions of what it means to be healthy. It is these gaps that this work seeks to address.

2.5 Conclusion

Concern about the health inequalities faced by ASRs is evident in the literature internationally and in the UK. Based on the knowledge that migrants in general and ASRs in particular often have poorer health outcomes than non-migrants, research has focused on what the reasons for this are and how services might be developed to overcome these barriers. Suggested barriers to access, both to primary and preventive care, range from structural factors, such as the barrier created by poverty, to organisational factors such as the lack of provision of appropriate information, to individual factors such as cultural differences in understandings of health and engagement with care. It is clear, however, that while structural aspects are often mentioned, the core focus of much of the research on ASR health is on cultural and behavioural aspects of health. The implication, therefore, is that it is at the individual level that blame is located and change is required to occur, removing responsibility from the systems that cause poor health in the first place (Viruell-Fuentes 2012: 2103; Castaneda et al 2015:379).

Kearns et al used epidemiological data to demonstrate the worsening health trajectories of asylum seekers in Glasgow (Kearns et al 2017). It is therefore crucial to explore what aspects of ASR experience in Glasgow impact on health and may result in poorer engagement with services. While the individual level experience is critical, it is clear that a social determinants approach, seldom used in migrant health research, can provide a richer picture of the factors affecting ASR health (Castañeda et al 2015:365; Viruell-Fuentes 2012: 2103). Indeed, Castañeda suggests that in this framework it is essential to consider the role of immigration itself as a determinant of health (ibid).

In the following chapter I consider what theory might facilitate a fuller understanding of the factors shaping access to primary and preventive care. I suggest the theory of candidacy (Dixon-Woods 2005) as a means through which to explore access to care and preventive practices from both the provider and service user angle. I argue, however, that it is only useful if framed by a perspective that examines the structural determinants of access, and so introduce the theory of structural vulnerability (Quesada et al 2011) to offer a macro-level perspective.

Chapter Three: Theoretical perspectives

To ensure that preventive approaches or interventions are meeting their target population or having the intended effect, an in depth understanding of two related issues is crucial: the factors affecting people's engagement with a) preventive health behaviours and b) with healthcare services that promote preventive health.

Understanding preventive health is particularly complex, touching as it does on a multiplicity of research areas. Indeed, research on preventive health has at times been argued to be under-theorised, limiting its scope to create effective change (Potvin 2005; Netto 2006; Larchanché 2012). I argue that to conduct research that more appropriately addresses the factors that influence both health behaviours and healthcare engagement (and thereby deepen understandings around prevention), it is necessary to draw influences from a breadth of theoretical perspectives. Here I explore two theoretical approaches: candidacy, a 'mid-range' theory used to explore access to healthcare for vulnerable groups¹⁹ (Dixon-Woods et al 2005), and structural vulnerability, derived from the field of critical medical anthropology, to consider how they might be integrated to provide a means to explore all the levels at which the health of vulnerable individuals is affected.

Before exploring candidacy and structural vulnerability, I discuss some alternative theories that I have chosen not to engage with, and briefly highlight why this is the case. Then, focusing first on the concept of 'candidacy', I consider its strengths and weaknesses. I explore its operational utility in relation to prevention, which I argue may require a shift in focus. Through an examination of the theory of structural vulnerability, I explore how critical theory might enable a research agenda that puts notions of social justice and equity at its core, exploring the political, social, and economic determinants of health and wellbeing but without erasing individual experiences. Lastly I consider how critical theory that makes explicit the role of power and the influence of the macro environment can be combined with the more micro-level theory of candidacy, exploring how these two perspectives might be brought together to form a coherent analytical lens. I argue that critical perspectives can help to elucidate issues that remain unclear and un-critiqued in the candidacy framework, and expand perspectives beyond a single service access angle.

¹⁹ While Dixon-Woods does not explicitly define the term 'vulnerable', the review covers people who are socioeconomically disadvantaged, minority ethnic groups, children, and older people.

3.1 Alternative theories

I explore in detail in Section 3.2 onwards the reasons why the theories of candidacy and structural vulnerability may be useful for ASR perceptions of, and engagement with, preventive health. I additionally explain how they fit with the two disciplinary perspectives that the thesis engages with – critical medical anthropology and primary care. However, there are, inevitably, other theories which may also have provided useful insight but with which I did not engage. I briefly discuss here the Patient Centred Access to Care conceptual framework as a potential alternative to the candidacy model, and syndemics theory as an alternative to structural vulnerability.

3.1.2 The Patient Centred Access to Care conceptual framework

As described in Section 3.2 the theory of candidacy was developed in response to the fact that other access to care theories have focused either on the demand side or the supply side, but the interplay between the two was little considered (Kovandzic et al 2011:764). Given that this thesis elicits perspectives from both ASRs and healthcare providers this aspect seemed particularly useful. To date, one other approach has been developed which also seeks to explore access to care as a dynamic process. The Patient Centred Access to Care conceptual framework, developed as part of the IMPACT (Innovative Models Promoting Access to Care) research program, similarly charts the path from perception of a healthcare need to the provision of healthcare for that need, and considers issues on both the provider and service user side (Khanassov et al 2016). In this way it is extremely similar to the candidacy framework. However, where candidacy has been used to examine access to care in multiple settings and by a variety of different researchers, the Patient Centred Access to Care Framework has so far only been used by the team that designed it. Given that it appeared extremely similar to candidacy, it seemed prudent to engage with a framework for which there is already a small (but growing) body of literature.

3.1.3 Syndemics theory

Critical medical anthropologists have utilised a range of theoretical tools in addition to the notion of structural vulnerability to understand the way that structural factors shape experiences at the micro level. One such example is syndemics, which is a theoretical perspective that explores the “synergistic interaction of coexisting diseases and biological and environmental factors that worsen the complex outcomes of those diseases in

populations” (Hart & Horton 2017:888). In particular, syndemic theory aims to explore two co-existing disease states in a population (e.g. diabetes and depression in Hispanic migrants in the US) and determine how upstream factors shape the presence of these co-morbidities (Willen et al 2017). In so far as the syndemics approach helps to elucidate the ways in which individual level health outcomes are caused and/or shaped by social, economic, and political factors, syndemics shares many of the strengths of the structural vulnerability framework and could provide utility for the research in this thesis. However, the syndemics approach starts with the presence of a set of co-morbidities in a population and then seeks to explain why the population has been made vulnerable in that way. The research in this thesis, on the other hand, explores vulnerability to risk of illness (in particular NCDs), rather than presupposing the existence of NCDs themselves. Further it does not seek to explore how different illness states coexist with one another. For these reasons the syndemics approach did not offer an ideal fit as a theoretical perspective, and I considered structural vulnerability (described in detail in Section 3.3) which explores the upstream factors that render individuals vulnerable to poor health to be more appropriate. A second potential alternative perspective is structural violence, from which the theory of structural vulnerability is directly drawn. Section 3.3.1 explains why structural vulnerability rather than structural violence was chosen.

3.2 Candidacy

A central aim of this thesis is to consider how one might think about preventive interventions and services for marginalised groups. Therefore, it is useful to start with a framework that focuses on service access and use. The theoretical concept of ‘candidacy’ (Dixon Woods et al 2005) can offer a particularly valuable means to explore the pathways to engagement with both preventive care *and* preventive behaviours and thus provides especial relevance to the focus of my research. Earlier theories of access to care sought to problematise the notion of access, distinguishing between *having* and *gaining* access to care (Aday & Anderson 1974), and considering the notion of ‘fit’ between service user and service provider (Pechansky & Thomas 1981). There has been confusion about the multi-dimensional nature of access, however, (Gulliford et al 2002:189; Macdonald et al 2016:167-8) and as a result theories of access have often focused either on help-seeking behaviour or on formal access to services (Kovandzic et al 2011:764). Candidacy is intended to bridge this divide and explore access from the perspectives of all the parties involved (users and providers), from the initial point of understanding oneself as a

candidate for a service to actually receiving that service. In particular, it draws attention to the social interactions that occur between the individual requiring access and healthcare professionals (or others providing the service).

The concept of ‘candidacy’ was originally developed by Dixon-Woods and colleagues following a critical interpretive synthesis of the literature on access to and use of services by ‘vulnerable’ groups (2005). It provides a model to understand access to healthcare, and describes the ‘way in which people’s eligibility for medical attention is jointly negotiated between individuals and health services’ (Dixon Woods et al, 2006: 6), charting the path that individuals must navigate in order to receive healthcare services. The path is divided into seven stages (see Figure 1 and Table 3), commencing with an individual identifying him or herself as a ‘candidate’ for a particular service and culminating in accessing and utilising that service (or not as the case may be). The stages in the framework are fluid, dynamic, socially constructed, and do not necessarily occur in a linear order (ibid). Indeed, it may be more helpful consider candidacy as a series of interlinking phases rather than as a pathway.

Candidacy has been used as a framework to explore health service access for a variety of different ‘vulnerable’ groups. Research using candidacy has considered numerous different topics including mental health access for hard to reach groups in Liverpool (Kovandzic 2011), access to healthcare for ethnic minority seniors in Vancouver (Koehn 2009), engagement with outreach and anticipatory care in Scotland (Mackenzie et al 2011), access to care for undocumented migrants in Canada (Chase et al 2007), and women’s experiences of accessing healthcare in prison in New Zealand (Abbott et al 2017). While Dixon-Woods et al encourage the testing of candidacy across all types of health services (2006:35), consideration of its application to prevention has been more limited.

As it is currently constructed, the candidacy model has several strengths that may allow insights into the health and wellbeing experiences of the participants and the perspectives of those who provide care. Indeed, there is a call for the model to be further tested in empirical health research to determine the bounds of that utility and suggest areas for refinement (Dixon Woods et al 2005; Mackenzie et al 2012:806). Here I explore some of the core tenets and strengths of the framework, namely that it i) understands candidacy to be a social construction and ii) provides a clear framework through which to examine care access. Candidacy is not a complete explanatory model, however, and many of the phases remain underexplored. In particular, the influence of structural factors on candidacy is largely missing.

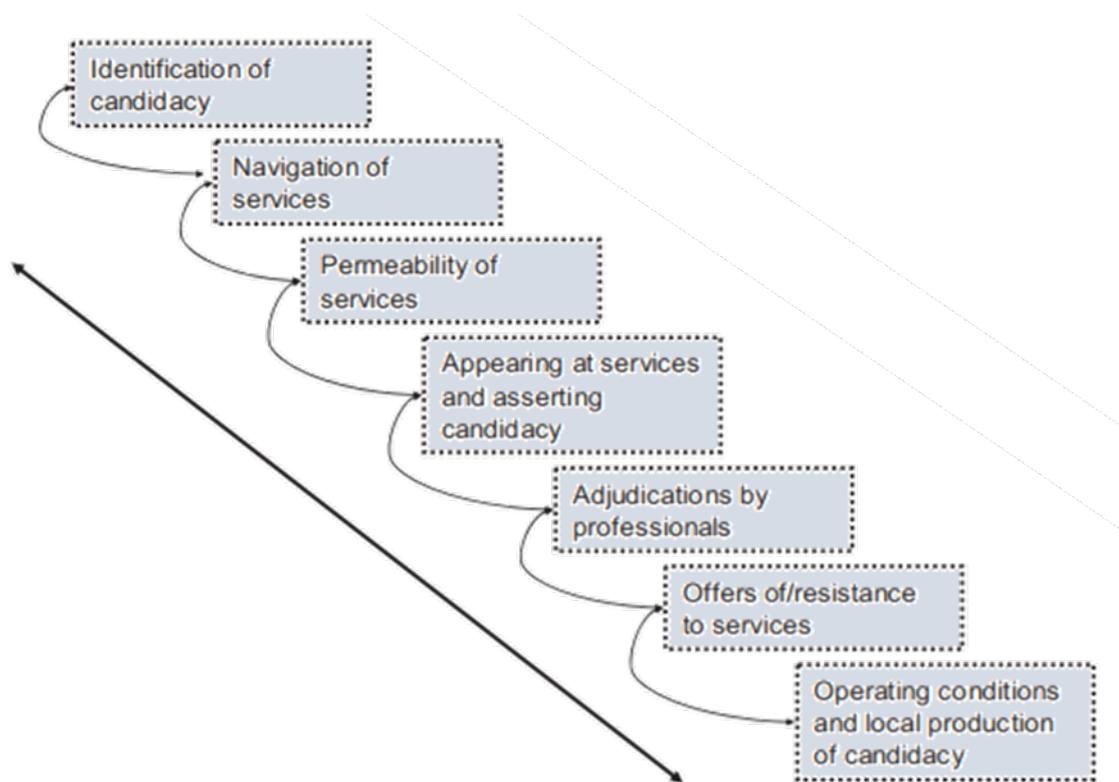


Figure 1: candidacy model as illustrated in Mackenzie et al 2013

Stage	Description
Identification	Refers to the point at which an individual identifies themselves as a candidate for healthcare (i.e. that they are in need of medical attention).
Navigation	The route to entry into a particular health service and the work an individual must do to get there.
Permeability	The ease with which an individual can access a service. Services can be more or less porous depending on what the barriers to access are.
Presentation	The act of asserting candidacy at a health service, either through an individual's own decision or by an invitation.
Adjudication	Here professionals judge whether an individual should be a candidate for a particular service. Judgements involve technical, social, and moral considerations.
Offers and resistance	The point at which offers of care are made. These may be accepted, but also potentially rejected for various reasons.
Operating conditions and local production of candidacy	The local influences on both patients and practitioners that affect the production of candidacy.

Table 3: Description of each stage of candidacy

3.2.1 The construction of candidacy

A central tenet of the candidacy framework is the understanding that candidacy for health services is a socially constructed concept. This opens the way to analyse critically the construction of candidacy by all the actors in the process. Candidacy is constructed both by service users, in the ways that they understand their candidacy for particular illnesses and then negotiate eligibility for services and also by professionals in the way in which they determine who is a candidate for a service (Mackenzie et al 2012:806). Underscoring this is the notion that understandings of candidacy are all equally valid (i.e., none are more true than others) and that candidacy and related knowledge about access is co-constructed between different actors (Koehn 2009:588). One must take care however to ensure that this assumption does not obscure the reality that there are many power dynamics at play in the construction of candidacy. Certain constructions, such as those of health professionals, are likely to be afforded more validity than others (Macdonald et al 2016).

Identification of candidacy is influenced by several factors including, potentially, age, gender, ethnicity, and cultural identity (Dixon-Woods et al 2005:7; Koehn 2009:591). While it is important to examine how these factors influence individuals' own candidacy construction, Koehn alerts us to the necessity of examining construction on the service side also. Koehn suggests, for example, that although it is often the case that services are designed with the intention of access to them being equitable, the design is often influenced by over generalized assumptions about certain 'groups' of individuals (e.g., the belief that ethnic minorities always look after their elderly relatives). This results in the 'othering' of those groups and the development of a less, not more, equitable service (2009:587).

The emphasis on candidacy as a constructed notion makes it a useful framework to conduct research that aims to interrogate understandings of candidacy among various actors (e.g., refugee and asylum seeker participants, public health professionals and primary care staff). It is important to ask ASR participants how they identify themselves in terms of seeking access or engaging in health 'behaviours' and determine what influences these perceptions. It is equally important to question how health professionals have constructed candidacy for different vulnerable groups and consider how this affects who is seen as eligible for care, and who is not. It is important to remember, and also to interrogate, the way in which candidacy is constructed not just by different groups independently of each other, but through a complex interplay between individuals and organisations.

3.2.2 Utility of candidacy as a framework

Dixon-Woods et al argue that notions such as 'access to healthcare' and 'equity of access' are vague and difficult to operationalise in practice (2005:6). Additionally, relying on service usage statistics as a way to understand healthcare access vastly oversimplifies a very complex process (Dixon Woods et al 2006:7). With this in mind, the theory of candidacy was developed with the aim of creating a more workable framework through which to interrogate issues around access to care. Additionally, it aims to go further by putting a focus on the negotiations and co-constructions that occur between service user and service provider. The intention is not simply to look at one-way notions of supply or demand, but to underscore the dynamic interplay between the two (Mackenzie et al 2011:351-2). Mackenzie et al note that explanations for the inequitable use of preventive services among 'marginalised groups' are often provided using the framework of supply (i.e. issues related to organisation and provision of services) and demand (i.e. service user

perspectives). Here candidacy provides an opportunity to look closely at all sides in the access process, to identify exactly where it is that problems occur.

Because the candidacy framework breaks the process of access into phases (with a complex interaction between user and provider at each stage), it provides a useful means of examining the precise points at which people are vulnerable. It might, for example, be at the phase where they recognise themselves to be candidates for a particular service (or do not recognise themselves in this way) or it may be at the phase at which they seek to use a service and must negotiate access with the gatekeepers of the service. Alternatively, it might be in their capacity to use a service once it has been offered (Dixon-Woods et al 2005: 9). Koehn, in her research on ethnic minority seniors in Canada was able to explore through this model the notion that it was language rather than ethnicity that was the most significant barrier as regards initial assertions of candidacy by her research participants (2009:593). While service providers might have considered that ethnic and cultural factors meant that seniors didn't identify themselves as eligible for services, in fact the more practical barrier of language prevented them from doing so, even if they identified themselves as eligible.

It is important to ensure, however, that the neatness of the framework, while a key strength, does not result in the adoption of a reductionist perspective on healthcare access, with each stage seen as discrete and linear.

3.2.3 Candidacy and prevention

Preventive healthcare is an extremely broad concept and though it involves engagement with services that fall within the remit of healthcare services (e.g., the now defunded Keepwell programme in Scotland²⁰), it touches on many other areas as well. Indeed, engagement with preventive health can be considered as widely as utilisation of green spaces for exercise, ability to purchase healthy food, and access to opportunities to enhance wellbeing. The model of candidacy was not developed with the concept of preventive health specifically in mind, but rather shorter term, acute engagements with healthcare. There has been limited research on the utility of candidacy in understanding either prevention or screening, with two exceptions being Mackenzie et al's study on outreach workers in Glasgow (Mackenzie et al 2011), and Normansell et al's paper on multi-ethnic, inner city young women's perspectives on screening for sexually transmitted infections

²⁰ This programme is described in Chapter Six

(Normansell et al 2015). Thus when considering prevention, the model of candidacy must be considered alongside perspectives that examine influences on health in their broadest sense. It can be argued that the issue of prevention in fact makes it necessary to bring in structural and macro-level issues, addressing one of the weaknesses of the framework.

An important consideration in terms of preventive care is differences in the first phase regarding initial identification of candidacy (see Table 3 and Figure 1). In the case of prevention, identification of candidacy is significantly more complex. For preventive interventions and screening programmes, it is often the health (or other) service that sets the agenda and determines that a particular group of individuals is a candidate for a particular programme (Mackenzie et al 2011:352). This does not mean however, that an individual's perception of their own candidacy will match with that defined by the service, and therefore individuals might either choose not to engage with a service that has been deemed relevant for them, or seek out preventive services for which they are not considered to be a candidate. Dixon-Woods, in a brief consideration of prevention, notes that asserting candidacy for prevention may actually require more work than for other healthcare services, particularly since it requires engaging with care when a person is ostensibly healthy (Dixon-Woods et al 2005:101). The notion of the 'inverse prevention law' corroborates this view, as it suggests that those with more resources (and less need to make use of preventive programmes) are more likely to engage in prevention than those with few resources, and thus prevention programmes can often make inequalities between those who engage and those who don't greater, rather than improving the health of those who need it most (Lorenz et al 2013). Engagement in prevention may also require assertion of candidacy multiple times, over a long time-frame (Mackenzie et al 2011:358).

3.2.4 Critiques of candidacy

Research that has utilised the concept of candidacy has identified a number of areas that require strengthening. Such critiques offer a useful opportunity to augment the model to better capture all the issues at play. Two significant criticisms are i) underdevelopment of the notion of multiple candidacies, and ii) the lack of attention given to the structural determinants of candidacy.

An area that is underdeveloped in the candidacy model is the way in which multiple influences and identities might impact on candidacy. Firstly, insufficient attention is given to the role of intersecting individual identities (e.g., the combination of socio-economic

status, gender and mental health status) that might diminish (or enhance) assertions of candidacy (Klassen 2008). Vulnerable individuals, the focus of the candidacy model, are likely to be vulnerable in more than one way. It is therefore important to elucidate how these sources of vulnerability might interact to impede access and engagement further, in addition to considering the effect they have on their own. The theory of intersectionality (Crenshaw 1999) which considers the impact of multiple intersecting identities is increasingly being engaged with in public health (e.g., Hill 2016; Kapilashrami 2015), and is implicit in this thesis. Additionally, although Dixon-Woods et al stress that the pathway to candidacy is not necessarily linear, the possibility that one might have different candidacies for different health conditions or services, including services outside of healthcare is not considered (Mackenzie et al 2012: 814). This is important because perceptions of candidacy or experiences of engagement in one area might have a direct impact on perceptions of candidacy in another. Because someone has asserted their candidacy for one particular service does not necessarily mean that they will do so for another of which they might also be in need. Kovandzic notes that certain health conditions (such as a mental health issue) might in themselves limit an individual's potential to assert his or her candidacy at all (Kovandzic 2011: 769). Another relevant consideration might be whether an asylum seeker's experience of regular and enforced interactions with Home Office officials might impact on their willingness to assert themselves with other 'officials', be they in healthcare, or another sector. With this critique in mind, there is significant theoretical depth to be added, in particular to the 'identification' section, to take into account notions of multiple candidacies, the ways in which identification might be culturally constructed and how intersecting identities might contribute to this.

A second important critique is of the limited attention given to structural factors in the generation of candidacy. The influence of structural factors on access and engagement with care is largely overlooked in the candidacy framework which focuses far more closely on individual and organisational engagement and negotiations (Chase et al 2017; Kovandzic et al 2011; Mackenzie et al 2011). Research that inadequately considers structure is clearly problematic if one is attempting to uncover the structural inequities and power imbalances that lead to unequal health outcomes (Bambra et al 2005; Baum 2010; Popay 2012). While the final stage of the candidacy model – operating conditions – considers some of the external influences on access, it focuses almost exclusively on local operating conditions, without exploring macro-level factors. This limitation means that many of the drivers of inequitable access to care still remain unexamined (Chase et al 2017:57; Mackenzie et al 2012: 806). At present, the political salience of health and migration policy is particularly

heightened, and this is further compounded by a turbulent economic context (Mackenzie et al 2012; O'Donnell et al 2016; Rechel et al 2013).

Rather than suggest that this limitation diminishes the utility of candidacy, it highlights the necessity of considering it in conjunction with other theoretical perspectives, so that the political and economic drivers of ill health and poor access to services are foregrounded and their influence on individuals' construction of candidacy properly interrogated (Mackenzie et al 2012: 15). Indeed, the use of the candidacy framework provides several opportunities to introduce critical theoretical perspectives and examine the role of power at the micro- and macro- level. Drawing notions of candidacy together with an exploration of how macro level factors and power relations (at both the micro- and macro-level) influence access may provide a more robust means to understand where inequalities in access may occur and what can be done to mediate them.

3.2.5 Moving toward a critical perspective

One critique of public health approaches (candidacy might be included in this regard), is that the wide-ranging, upstream potential determinants of the health of 'vulnerable' groups (e.g., racism, discrimination, immigration policy) do not neatly fit into most public health explanatory frameworks (Page-Reeves et al 2013b:31; Raphael & Bryant 2015:2; Smith & Eltani 2014:13). To address this, and to respond to the calls for greater theoretical depth in public health research, it is crucial to consider what approaches, methods, and concepts might appropriately be deployed to explore the dynamic links between structure, agency and power relations, and the ways that those relationships might influence health and wellbeing. Critical perspectives from the social sciences can be instrumental in helping to unpack these complex issues. Additionally, they may provide a way to forge a public health research agenda with an explicit social justice objective that can generate evidence for the development of interventions that challenge the factors that lead to poor health outcomes at every level from the micro to the macro.

3.3 Structural vulnerability

I suggest that integrating candidacy with the critical theory of structural vulnerability can begin to build a more useful model through which to conceptualise access to and engagement with preventive health and preventive healthcare. In this manner, candidacy can act as a useful heuristic device to provide shape to a more nebulous theory and make it

more accessible and useful to applied public health research. The concept of structural vulnerability offers an illuminating lens through which to understand how individual experiences of health and wellbeing relate to macro-level social, political, and economic forces. As a theory it forms part of the 'toolkit' of critical medical anthropology which as a discipline aims to examine 'interpretations of local meanings and experiences while linking these interpretations with an analysis of larger social, political, and economic forces' (Holmes 2006:1780).

3.3.1 Origins of structural vulnerability

The principle critical theory engaged with in this thesis is that of structural vulnerability (Quesada et al 2011). However, before describing this in detail, it is important to trace its historic development. Structural vulnerability grew out of the concept of structural violence (Galtung 1975:173 quoted in Quesada et al 2011:340) and is also heavily influenced by Bourdieu's notion of symbolic violence. In Section 3.2.1 I provide a brief overview of these two theories, before moving the focus to structural vulnerability.

Symbolic violence is one of the key theoretical concepts of the French sociologist Pierre Bourdieu (Bourdieu 1990). It describes the violence that is enacted upon individuals through their own complicity due to the ways in which social and structural inequalities become naturalised and embodied (Quesada et al 2011: 342). Individuals therefore act subconsciously in ways that reinforce their subjugated position (Bourdieu and Wacquant 2004:272). For example, in Holmes' research on Mexican immigrant farmworkers he notes that the farmworkers were arranged in an informal hierarchy (based on factors such as ethnic status) and that each believed the place in which they found themselves to be natural and deserved (Holmes 2012:880). The concept of symbolic violence illustrates the complexity of the relationship between structure and agency in determining human behaviour, because although embodied inequalities are structurally determined, they are actively reinforced through individual agency (Bourdieu and Wacquant 2004:272). The effects of symbolic violence - the naturalisation and reinforcement of hierarchy and related inequalities - create fertile ground in which structural violence can occur. While this concept is extremely useful, the capacity of individuals to recognise and reject the 'violence' that is meted out to them must not be underestimated.

Structural violence overlaps significantly with Bourdieu's concept of symbolic violence, though is perhaps more explicitly political in its intentions and implications. It was

originally defined by Galtung to describe ‘the indirect violence built into repressive social orders creating enormous difference between potential and actual human self-actualization’ (Galtung 1975:173 quoted in Quesada et al 2011:340). More recently, the physician-anthropologist Paul Farmer has developed the notion of structural violence as an analytic tool to examine how historical, political and economic forces combine to put certain groups and individuals in positions and situations where they are extremely vulnerable to ill health (Castañeda 2013: 95).

The theory of structural violence explicitly emphasises the direct connection and causal link between the fact that some individuals have the capacity to lead lives largely unencumbered by poor health (or poverty) while others do not (Farmer 2005:30). Therefore, individuals on the ‘right’ side of the economic divide benefit from structural violence as much as those on the ‘wrong’ side suffer because of it. Structural violence (as with symbolic violence) differs from individual or institutional violence since it can’t be traced to individuals or institutions but instead is present in all-pervasive structures (Farmer 2004; Farmer 2005).

A growing literature in medical anthropology and more recently public health has used the concept of ‘structural violence’ as an analytical tool to explore the factors influencing migrant health and migrant healthcare access as well as the health of various other marginalised groups (e.g., Holmes 2006; Page-Reeves et al 2013a; Page-Reeves et al 2013b). While various types of inequality can contribute to structuring ill health, the main focus in analyses of structural violence is on economic determinants, in particular the ways that macro-level economic structures filter down to enact ‘violence’ on certain individuals (Holmes 2006:1789). Holmes, for example, describes the structural violence experienced by Mexican immigrant farmworkers in California as ‘enacted by market rule and then channelled through international and domestic racism, classism, sexism, and anti-illegal immigrant sentiments’ (Holmes 2006: 1789).

While structural violence can be highly illuminating as an analytical frame, it is important to be mindful not to employ the concept uncritically. It can be tempting to start to consider inequality as a homogenous concept rather than to look at the specific mechanisms through which different axes of inequality impact on individual health (Bourgeois and Scheper Hughes 2004b).

3.3.2 Theorising structural vulnerability

‘Structural vulnerability is ‘a positionality that imposes physical/ emotional suffering on specific population groups and individuals in patterned ways, structural vulnerability is a product of class-based economic exploitation and cultural, gender/ sexual, and racialized discrimination, as well as complementary processes of depreciated subjectivity formation’ (Quesada et al 2011: 340)

Recently, the work of Quesada and Bourgeois has considered how to take a more nuanced approach to the analysis of structural violence. They propose that the term ‘structural vulnerability’ could better encompass the influence of ‘cultural, gender/sexual and race-based discrimination’ as well as economic inequality (Quesada et al 2011:340). The notion of structural vulnerability is thus viewed as an analytical tool to examine the multiplicity of ways in which structural factors might render individuals or groups of individuals vulnerable to poor health and/ or inequitable access to care. Given that it widens the focus of analysis from the economic sphere, it might be a more nuanced tool for introducing a structural account of health into public health research (Quesada et al 2011:341).

Structural vulnerability builds on Bourdieu’s notions of symbolic violence through the argument that the structural (historical, social, political, economic) context in which individuals find themselves is reflected in their sense of agency, how they understand their own health and wellbeing and entitlements to healthcare (Quesada et al 2011). For migrants, such factors might include the healthcare context in their country of origin, context of their migration, attitudes towards migrants in the UK (on the part of the media, political establishment and general population), and the ways in which their rights and entitlements are constructed, and racism at an individual, institutional or structural level (Castañeda et al 2015; O’Donnell et al 2007; Zimmerman et al 2011). This is not to deny that individuals exist as active agents and may often contradict these influences, but it is important for understanding how agency is constrained and how a constellation of different factors (e.g., gender, ethnicity, migration status) can interact to put individuals in positions that can limit their health, wellbeing, and ability to access care.

Quesada et al’s notion of structural vulnerability provides greater utility than the original concept of structural violence as it emphasises the role of multiple sources of inequality in addition to economic inequality and stresses the importance of understanding how different axes of inequality intersect to put individuals in increasingly vulnerable positions (Quesada

et al 2011). This approach is useful for demonstrating the need for social and political action alongside clinical efforts as well as for identifying which actions might be most appropriate (Quesada et al 2011: 345). I explore below the various ways in which a critical perspective might bring utility to public health and primary care research. Although the literature described below draws on both structural violence and structural vulnerability, the latter, with its broader perspective, is a particularly appropriate additional lens for the work undertaken in this thesis.

3.3.3 Unpacking perceptions

Theories of structural violence and vulnerability provide a lens through which to understand how perceptions about migrants and migrant health are formed, why this happens and what the implications are. Holmes, reflecting on his work with indigenous Triqui Indian migrant farm workers in the United States discussed the various influences on physicians' perceptions of the migrants, suggesting that they are developed 'partially through brief clinical encounters, partially through related experiences in medical training, and partially through narratives read and heard in the popular media and in everyday public discourse' (Holmes 2012:878). Similarly, Larchanché, in her research on undocumented migrants in France, observed how perceptions at both individual and institutional levels are the result of a 'long term accumulation of representations' relating to historical and social contexts (Larchanché 2012:859). Further, social inequalities come to be taken for granted and naturalised, leading to negative perceptions of migrants becoming ingrained and impacting on the services provided and the attribution of responsibility for illness. This inevitably has a negative impact on migrant health (Holmes 2012).

Holmes underscores the importance of examining how exactly these processes occur and how they express themselves (Holmes 2006). One particular way in which this might manifest is through the choices that public health and health service providers make in terms of the particular illnesses that are often the focus of migrant healthcare. For example, though migrants are at significant risk of NCDs as well as infectious diseases, moral concerns about migrants as vectors of contagion appear to have influenced academic and public health priorities in this area (Castaneda 2010:16).

A further perception worthy of unpacking (and discussed also in Chapter Two) is demonstrated in the paradox exposed by Larchanché whereby although undocumented migrants have the 'right' to access healthcare services in theory, they are, at the same time,

constructed as an illegitimate group who are not deserving of free care. This construction of illegitimacy can be traced to a combination of factors, including longstanding xenophobia, restrictive immigration policies, the economic crisis, and high levels of unemployment (Larchanché 2012: 859). Crucially, not only are perceptions of undeservingness adopted by non-immigrants, but undocumented migrants also come to see themselves as undeserving, itself a form of violence. This inevitably limits their ability to access healthcare services in practice and contributes to their poor health (Larchanché 2012: 858).

3.3.4 Integrating the individual with the structural

While the notion of structural vulnerability places a significant emphasis on structure, rather than behaviour, as a determinant of individual outcomes (health and otherwise), its roots in critical medical anthropology ensure that the presence of individual and cultural differences is not ignored either. While the determinants of health outcomes may be structural, they play out at the individual level, and it is this level which has meaning for individuals. This has important implications for two concepts which are often considered in an individualist frame, but are in fact structurally shaped: culture and risk. By thinking about culture²¹ through a structural vulnerability lens, it is possible to underscore its relevance without falling into some of the traps that public health research inadvertently does, where ‘culture’ can be reified and seen as the reason for differences in health outcomes (Quesada et al 2011:340; Page-Reeves et al 2013b:42). Using a critical lens, cultural difference is acknowledged within the social, political and economic context that structures it (Sargent & Larchanché 2009:2).

Dynamic conceptualisations of culture further encourage a set of questions that might not normally be considered in public health research. In particular, it raises the question of how concepts such as ‘migrant’, ‘ethnic minority’ and ‘culture’ are understood by both migrants and service providers and how that might influence the way that (preventive) care is provided and engaged with. Asking these questions can provide important insight into the assumptions that are implicit when we talk about the health of migrants and ethnic minorities and explore where there might be racial bias or stereotyped assumptions, even when this might be subtle or unintended.

²¹ See chapters one and two for further analysis of the use of the term ‘culture’ in public health.

The notion of risk has been conceived of in a plethora of ways (Lupton 2013). In public health there is often a focus on individual ‘risk behaviours’ being the cause of ill health which has led to the development of highly individualised behavioural interventions (Baum 2010: 36; Rhodes et al 2011:207). The framework of structural vulnerability can provide an alternative conceptualisation of risk however that moves away from the individual. It may be more helpful to explore how structural constraints and social inequalities shape the risks that are imposed on individuals, and how social conditions are embodied at the personal level. (Quesada et al 2011: 343; Rhodes et al 2011:207). For example, Rhodes et al sought to develop a deeper understanding of HIV risk for marginalised populations. Building on the notion of structural vulnerability, they developed the concept of the *Risk Environment* as a way to explore all the macro-level factors that influence marginalised individuals’ personal risk of contracting HIV. They argue that this allows a move towards a social understanding of HIV vulnerability where it is not individuals who are considered risky (and therefore at fault) but situations or structures that are considered as risky (Rhodes et al 2011). An important aim of this thesis is to explore what structural determinants impose vulnerability to NCDs on ASRs and, indeed, other marginalised groups.

3.3.5 Moving beyond social determinants of health

The macro-level focus of structural vulnerability shares much with theoretical approaches that draw on the social determinants of health. Social determinants of health (SDH) approaches have been instrumental in identifying the wider determinants and contextual factors affecting individuals’ health and wellbeing, and reframing topics which are often the purview of behavioural health research which places excessive responsibility on the individual (Page-Reeves et al 2013a; Page-Reeves et al 2013b). However, these approaches have been critiqued for operating within a particular (neoliberal) political context that does not allow for a sufficiently thorough analysis of how unequal power relationships contribute to poor health (Friedli 2013; Krieger 2008). As a result, ‘lifestyle drift’ often occurs in SDH research, whereby solutions to public health issues are recommended at the individual level even when the intention was to provide a social determinants account (Bambra et al 2005:189; Brassolotto et al 2012:323; Popay 2012:60). Phelan et al note that the tendency to focus on the mediating factors that lead to unequal health outcomes means that the ‘fundamental causes’ remain untouched, and health inequalities persist (Phelan et al 2004:267). Additionally, analyses tend to stop short of describing (or attempting to describe) exactly how it is that structural determinants operate,

instead simply demonstrating that they are present (Page-Reeves et al 2013b). Lastly, SDH researchers focus on quantitative measure of inequalities to the exclusion of qualitative research which is able to capture the lived experience of inequality in a way that quantitative research cannot (Elliott et al 2016:223-4).

Critics of SDH approaches call for a number of changes to the ways that health inequalities are conceptualised. Two particularly important calls are i) for the political nature of health inequalities to be foregrounded, and ii) for there to be greater interrogation of the ways in which structural inequalities are expressed at the individual level.

Bambra et al emphasise that health is inherently political because *'some groups have more of it than others, the social determinants are amenable to political interventions, the right to health is fundamental to citizenship and human rights, and because power is exercised over it as part of a wider economic, social, and political system'* (Bambra et al 2005:187). However, because SDH research is too often constrained by the political context in which it takes place, the political nature of health, and link between power inequities and poor health is obscured (Bambra et al 2005:192; Krieger 2008:223; Smith & Eltani 2014:6). There is therefore a call for research in this field to move towards a 'politics of health' (Bambra et al 2005), which better accounts for the role of power in shaping health inequalities (Krieger 2008).

Central to the theory of structural vulnerability is the question of how power inequities are reflected in unequal health outcomes, an approach that is inherently political. Because of this, research that uses a structural vulnerability or structural violence framework has been able to demonstrate the political nature of health. In a study of migrants at risk for diabetes in the U.S., Page-Reeves et al note how utilising a structural violence framework illuminated how fear related to migration status and engagement with medical authorities was highly relevant to the ways that migrants responded to diabetes risk (Page-Reeves et al 2013b:42). Similarly, Larchanché notes that it is the interaction between a variety of 'intangible' factors: 'social stigmatization, precarious living conditions, and the climate of fear and suspicion generated by increasingly restrictive immigration policies' that diminishes feelings of entitlement to healthcare by undocumented migrants in France and thereby creates barriers to access (Larchanché 2012: 858). Sargent and Larchanché also demonstrate how the political determinants of the health of undocumented migrants in Paris are obscured when psychiatric solutions are sought for migrants' problems, rather than there being any attention paid to their 'political and economic precarity' (Sargent &

Larchanché 2009:4). In the UK, the political determinants of migrant health are equally clear, with the 2014 UK immigration bill suggesting that health professionals should be asking about their patients' migration status (Wind-Cowie & Wood 2014).

The second change that is called for relates to a concern that SDH can often be too abstract with insufficient attention paid to how factors at the macro-level express themselves at the individual level and how macro-level factors intersect with various aspects of identity beyond socioeconomic status (Kapilashrami et al 2015: 302). This relates to the critique that SDH researchers have tended to ignore ethnicity and migrant status, which was discussed in Chapter Two. Raphael suggests, for example, that it is necessary to explore how 'social determinants and their distribution mediate the vulnerabilities of those occupying specific social locations, such as being of Aboriginal descent, an immigrant, female, person of colour, unemployed, ill, having a disability and being working class (Raphael 2012b in Raphael & Bryant 2015:7). Popay similarly calls for research that examines the pathways between inequality at the macro-level and poor health at the individual level, because although inequality might be structurally determined, the way in which it manifests in individuals' lives is equally important (Popay 2012:60). Because SDH research operates at a high level of abstraction, and the root causes of health inequalities tend to fall outside of the health and social care sphere, addressing inequalities within clinical encounters or health improvement interventions is particularly challenging. Following through on Popay and Raphael's suggestions to understand individual level manifestations of inequality may provide an opportunity to demonstrate their relevance in these spheres. Here, structural vulnerability's roots in critical medical anthropology are crucial, since the discipline calls for exploration at the individual level while maintaining a focus on structural determinants.

3.4 Constructing a comprehensive analytical lens

It is well recognised that an understanding of the relations between structural inequality and agency and micro- and macro-level influences on health is crucial, both in efforts to understand inequalities in health (Karlsen & Nazroo 2002:1) and in the development of policies and interventions aiming to reduce health inequalities or meet the needs of diverse groups (Kovandzic et al 2012:546). Indeed, an effective exploration of the factors affecting adoption of preventive health behaviours and use of preventive health services (as with other public health research) demands a lens that can look closely at micro-level processes and interactions but frame them in terms of the way that they are shaped by local and

global historical, political and economic practices (Bourgeois and Scheper Hughes: 2004: 318; Kovandzic et al 2012:537). As is evidenced by critiques of both behavioural health research and social determinants of health research (see Chapter Two and Section 3.2), however, there are many potential pitfalls when charting a path to achieving this in practice. It is therefore useful to consider what perspectives might bring us closer to success in this regard.

The theories of candidacy and structural vulnerability can provide valuable insights for research that explores perceptions of keeping healthy and access to (preventive) care for ‘vulnerable’ groups. I argue that when considered in conjunction with each other, they can serve to enhance each other, offering a research perspective that is not only theoretically robust, but also has practical utility. Here I explore some of the ways that a dual focus on candidacy and structural vulnerability might prove useful, and examine how each concept can help to address deficiencies in and enhance the other. In particular, I discuss how, when considered in conjunction with each other, these frameworks allow for an analysis that i) has significant breadth and depth, and ii) helps draw understandings of structure and agency together to develop a more dynamic approach.

3.4.1 Breadth and depth

While the concept of candidacy is useful for considering those aspects of preventive health engagement that relate to uptake of services or interventions, be they in the field of healthcare or otherwise, addressing preventive health requires an understanding that extends far more broadly than just service uptake or access. A structural vulnerability approach immediately encourages us to frame the candidacy journey within a wider context that takes into account both the micro- and macro-level factors that influence engagement with preventive health. This includes history and political economy but also local environment and culture.

The final phase of candidacy, ‘operating conditions’, benefits greatly from the broadening of perspective offered by a structural vulnerability lens. For Dixon-Woods et al, operating conditions referred only to the ‘locally specific influences on interactions between practitioners and patients’ (2006:8), however influences on the candidacy of vulnerable individuals extend far further than this. Through a structural vulnerability perspective, this analysis may be significantly extended. At the meso-level, considerations of operating conditions may be broadened to explore issues such as geographic space which may affect

the services that individuals are willing to use. For example, Kovandzic et al note that the ways that Somali refugees in Liverpool mapped their surroundings didn't always concur with the ways that service providers mapped a local area. Thus, a service that is considered to be within a particular neighbourhood by one group may not be considered so by another (Kovandzic et al 2012:541). This may be further complicated by the fact that migrants may move location fairly often, but wish to maintain connections in other parts of a city (ibid). At the macro-level, structural factors relating to history and political economy and cultural context may become central to the notion of 'operating conditions'.

This approach raises several opportunities to ask different types of questions when exploring engagement with preventive health by African migrants in Glasgow. For example, has the categorising of certain groups of migrants as candidates for specific diseases (e.g., African migrants targeted as at risk for HIV/AIDS) meant that they do not consider other illnesses for which they might be equally, if not more, at risk? Has the targeting of Africans for HIV services turned them away from engagement with other health services or preventive health services in general? How does the political and media context as it relates to migrants in Glasgow affect the way that health provision is perceived both by migrants and service providers? Do structural inequalities hinder identification of candidacy for services? Are there negative issues that need to be addressed, or conversely are there positive aspects of the Glaswegian context that might be replicated elsewhere? The answers to these questions have important implications for several different stages of the candidacy journey, such as how it is that individuals identify themselves, who is able to set the agenda and in what broader 'operating conditions' do the assertion of candidacy takes place in.

Every phase of the candidacy journey involves a negotiation between different actors, whether explicitly in the 'presentation' and 'adjudication' phases in which candidates present themselves to services and their eligibility for those services is then considered, or in the identification stage where individuals or service providers identify themselves as candidates for an intervention or service. What is missing from the candidacy framework, or at least not explicitly addressed, however, is the role of power relations in mediating those negotiations. Groups of individuals, (e.g., refugees, migrants, asylum seekers) are often considered to have particular sets of health needs, which may or may not be predicated on epidemiological evidence. When considering *who* sets the agenda in terms of what interventions or services are deemed most appropriate for different individuals, it is not enough to simply acknowledge that differences in opinions may occur between users

and service providers. The power dynamics at the heart of discordant (or concordant) attitudes, the impact this has on the types of services that are provided, and the various actors (and their relative influence) that play a role in this must be interrogated. This is particularly the case for prevention where often certain demographics are specifically targeted to receive a service. Bringing together candidacy and structural vulnerability is particularly useful here, since while structural vulnerability encourages us to examine how power operates on a global scale, it is important to focus on how it operates in daily life also (Green 2004:319).

3.4.2 Bridging structure and agency

In their positioning of the individual, the concepts of candidacy and structural vulnerability may initially seem at odds with one another. While candidacy focuses largely on the micro- and meso-level, structural vulnerability puts its attention on the ways that broader structures render individuals vulnerable. However, this does not necessarily mean it sits at odds with a framework that examines individual level processes and individual actions as candidacy does. This is because its anthropological bent lends itself to a concern for the ways that individuals express themselves, and the influence of structural, social and cultural factors on this. Drawing on Bourdieu's notions of habitus and symbolic violence, individuals are influenced by, embody, and then reinforce the structures in which they are situated (Bourdieu & Wacquant 2003).

Indeed, the bridging of these two theories may provide a pathway through which to explore the mechanisms by which individual and structural factors combine to influence health outcomes and engagement with healthcare. Each interaction within the various stages of candidacy can be interrogated with a consideration of the agency-structure dynamic influencing it. With the appreciation that both agency and structure have a role to play in determining health outcomes, a research perspective can be forged that is neither overly deterministic, nor falls back on individual responsibility. It may therefore be possible to determine at what points a focus on structure would be most useful and where a focus on the individual may provide benefit.

3.5 Conclusion

By drawing the notion of structural vulnerability together with the framework of candidacy, I have demonstrated how it is possible to reframe questions of importance to

public health and primary care research so that structures rather than individuals are the central research focus. While the individual must not be removed from consideration, I argue that the only way that preventive approaches can serve to promote health equity is if understandings of health and prevention are broadened to consider a) the influence of political, social, and economic structures and b) the power dynamics inherent in these structures. By drawing on these approaches I have sought to conduct research that has both theoretical complexity and public health applicability. Chapter Four considers how these approaches were operationalised through the methods employed in the fieldwork for this thesis.

Chapter Four: Methodology

This chapter outlines where my qualitative research is methodologically situated and describes the process of designing and analysing the focused ethnography I carried out.

In section one I ground my research in the two disciplines that influence this thesis - critical medical anthropology and primary care - and explore how these disciplines have shaped my methodology. Next, I consider various research paradigms from realism, to social constructivism, and outline the social constructivist approach I am taking. Lastly I consider a number of methodological ‘challenges’, namely the quest to ensure rigour in qualitative research, and the role of power and reflexivity in the research process.

Sections two and three proceed to the methods used in the thesis, detailing the design and analysis of the focused ethnography. I discuss each aspect of the focused ethnography and explore how it developed over the course of the research. I demonstrate how the principles outlined in part one on methodological perspectives are reflected in both the design and the analysis of the research.

4.1 Methodological Perspectives

4.1.1 Developing a disciplinary orientation

The research in this thesis sits at the intersection of the disciplines of critical medical anthropology and academic primary care and the methods described in this chapter are reflective of this. Here I describe briefly the principles of the two disciplines and explain how they complement each other.

Critical medical anthropology (CMA) is a branch of medical anthropology defined as:

‘a theoretical and practical effort to understand and respond to issues and problems of health, illness, and treatment in terms of the interaction between the macro level of political economy, the national level of political and class structure, the institutional level of the healthcare system, the community level of popular and folk beliefs and actions, the micro level of illness experience, behaviour and meaning, human physiology and environmental factors’ (Singer 1995:81)

Critical medical anthropologists understand health to be a political issue and relations in the health arena to be imbued with power dynamics (Singer 1995:81). Rather than

considering individual experience and broader contextual factors as distinct, CMA encourages a holistic approach that examines how micro-, meso-, and macro-level factors intersect and interact to produce health outcomes (Page-Reeves et al 2013a:1). In taking this approach, interpretations of local meaning are linked with analyses of social, political, and economic structures (Holmes 2006:1780). CMA lends itself to engaged and community-based research methods to reach a point where actual change can occur (Singer 1995:81). Page-Reeves et al, employing CMA in their public health research, argue for the necessity of methodological processes that examine the ways in which ‘social practices are produced’, if we want to move beyond behavioural paradigms that have had limited success (2013:4). Indeed, most critical theorists focus on establishing more equality in the research process with the aim of conducting research with the potential to have emancipatory effects (Ormston et al 2013: 16). This aim is not, however, without significant challenges (particularly when employed in public health), as the conclusions that can emerge in such an approach do not lend themselves to easily achievable actions.

An orientation informed by CMA lends itself to methods that seek to:

1. engage with a ‘community’ to understand its felt needs
2. explore influences on health from the individual to the macro-level and, crucially, examine how these interact with each other
3. interrogate the relationship between structure and agency in producing health outcomes
4. be in-depth and nuanced
5. undermine, rather than reflect or reinforce, established unequal power dynamics.

(Singer 1995; Page-Reeves et al 2013a)

Academic primary care, conversely, is a distinctly applied discipline, seeking to improve policy and practice as relates to primary care provision (sapc.ac.uk/about). As academic primary care often focuses on the provision of healthcare to individuals, it takes a more micro-level approach than the related discipline of public health. That said, it does not consider the individual in isolation. The declaration of primary care’s founding principles at Alma Ata in 1978 emphasised the pursuit of social justice and highlighted primary

care's role as the mechanism through which all individuals could obtain 'a level of health that will permit them to lead a socially and economically productive life' (Declaration of Alma-Ata 1978:1). As a discipline, primary care uses numerous methodologies, both qualitative and quantitative. However, qualitative health services research has been criticised for paying insufficient attention to theory and thus foregoing a level of analytic depth (Potvin 2005).

Since both disciplines are interested in the experience of the individual, and frame their approaches within broader notions of social justice, there is a synergy that suggests approaches from the two disciplines can work in concert with one another. The lens of critical medical anthropology provides a constant reminder to examine how macro-level factors are being expressed at the micro-level and to ensure that structural problems are not expressed as individual ones. The lens of primary care helps maintain a focus on what can be achieved practically at the level of service provision and thus address some of the concerns that critical medical anthropology cannot offer achievable solutions.

Framing my research within these two paradigms has led me to a methodological position that is theoretically informed, 'politically' oriented, and grounded in lived experience. This does not suggest that the research is constrained by a certain political position or only seeks to understand the issues within a particular context (indeed my thematic analysis was conducted without any a priori analytical framework), but rather that the chosen methods attempt to reflect the above principles. The practical impact of the principles has been to lead me to choose methods that i) are community engaged, ii) are committed to undermining the power imbalances present in society that can be reinforced through research (Rogers and Kelly 2011:398), and iii) enable me to explore fully the issues I seek to elucidate (specifically how micro- and macro-level factors interact in the production of health outcomes and perceptions).

4.1.2 Positivism, social constructivism and critical realism

Having a sound grounding in philosophical orientation can help to strengthen research practice (Ormston et al 2013: 2) and it has been important to reflect on the epistemological and ontological underpinnings of my research. The orientation of social science research can generally be placed somewhere on a continuum, between realism and positivism at one end, and idealism and constructivism at the other. Where realism and idealism are

ontological positions (i.e., they characterise how we understand reality), positivism and constructivism are epistemological positions (i.e., they characterise how we understand knowledge and its production) (O'Reilly 2012:54; Ormston et al 2001: 6).

Positivism as a term in the social sciences was first coined by Comte, who wished to define a method for social science enquiry akin to that in the natural sciences (Cruickshank 2012:72). A purely positivist approach considers the social world to exist in the same way as the natural world. All knowledge is fixed and knowable, waiting to be discovered, and therefore deductive approaches that seek to test hypotheses are common (Ormston et al 2013: 6; O'Reilly: 2012:49-50). Social constructivism, conversely, considers all knowledge to be socially constructed and thus no knowledge exists beyond the individual constructing it (Ormston et al 2013: 16). Additionally, all knowledge claims are an expression of power relations, which explains why some are given so much more credence than others (Burr 2003 in Cruickshank 2011:71). Such a perspective is useful for researchers who are exploring individuals' lived experiences since it is the reality of the individual that is foregrounded rather than any overarching 'truth'. My research, which explores meanings and experiences of health and wellbeing draws on social constructivist approaches.

This approach cannot be adopted uncritically, however. Although researchers employing social constructivist approaches do not necessarily subscribe to this view, when taken to its logical conclusion, social constructivism adopts a fundamentally relativist position, where no truth or knowledge is considered any more valid than any other (Cruickshank 2012:71; O'Reilly: 2012:54). This conflicts with the 'critical' position taken by many social constructivist researchers who often have explicitly political goals or underlying ethics (Cruickshank 2011:71).

Critiques of social constructivism are often made by critical realists who generally sit between the two poles described above. While this school of thought follows a realist ontology (and in fact emphasises ontological questions over epistemological ones) that there is a reality existing external to our awareness of it (Bhaskar in Cruickshank 2011:71) significant focus is placed on the lens through which this 'reality' is mediated. However, because it is acknowledged that an underlying reality exists, an important aspect for consideration is underlying causal and structural phenomena (O'Reilly 2012:55). This approach arguably has considerable value if we wish to examine or deepen our

understanding of how structure and agency interact to produce health (and other outcomes) and seek real improvements in health.

Similarly, Obrist et al 2010, discussing the role of anthropological perspectives in public health research critique a simple social constructivist perspective. Instead they propose a modified social constructivist perspective that considers individuals as actors existing within a particular social, cultural and structural framework about which broader inferences can be drawn.

Ormston et al note that methods and research positions should be considered as guides or learning devices rather than fixed principles to which one must subscribe (2013:19). Thus while my research perspective is broadly a social constructivist one, my focus is on the construction of perceptions of health and wellbeing - I do not take this position to its logical extreme. My research is underpinned by a number of political and ethical principles (as influenced by critical medical anthropology), and, importantly, I seek to determine underlying structural phenomena that may influence the health and wellbeing of the participants.

4.1.3 Rigour in qualitative methods and analysis

Much has been written about the most effective ways to ensure rigour in the design and analysis of qualitative research, with checklists being developed against which qualitative research papers might be judged (e.g., CASP 2013). This emphasis is important, since it allows researchers to demonstrate that qualitative research is a carefully considered, precise, organised scientific process with clear requirements in terms of both the conduct of research and the analysis of data (Ziebland & McPherson 2006). However, in efforts to demonstrate that our research stands up to standards of rigour and reliability (e.g., through demonstrations of triangulation of data or well described processes of analysis), it is important to ensure that the complexity of qualitative research is not underplayed. Indeed, a drive for 'technical essentialism' over analytical complexity can significantly diminish the value of qualitative research and suggests that our qualitative tools can tell us considerably more about 'reality' than they actually can (Barbour 2003:1020). This indicates a far more positivist approach than that which underlies most qualitative research. Barbour criticises this misunderstanding of what rigour means in qualitative research, where the 'practical' is considered more important than the 'analytical' (2003:1020). Similarly, Lambert & McKevitt warn against the moves to separate theory from method as

researchers seek to show how their research is 'objective' and rigorous (Lambert & McKevitt 2002:210). Although I aim to take a practical approach in this thesis, both the methods and the analysis are theoretically informed.

Rigour in qualitative research, while extremely important, needs to be considered in a broader and more nuanced fashion. For example, Bandyopadhyay notes that there are other considerations that have an implication on the rigour with which ethnographic research is conducted (2011:7). These may be equally important though more difficult to quantify. Such other considerations include maintaining the flexibility to participate in research at short notice and efforts to establish rapport with research participants leading to the collection of richer data (Bandyopadhyay 2011). A further important consideration, rather than emphasising efforts to maintain objectivity, is to examine critically the role of the researcher in generating qualitative research data (Oakley 1981:41).

4.1.4 Reflexivity & power in the research process

The grounding of my research in critical medical anthropology and the social constructivist stance I have taken, led me to two important (and related) considerations regarding the relationship between researchers and participants. These considerations are crucial for all qualitative researchers, but perhaps even more significant when research is being conducted with groups that are considered as vulnerable or marginalised.

It is important to consider the ways in which the research process can replicate existing social hierarchies. In particular, I was aware that my position as a white middle-class woman, member of an 'elite' institution (a university), and UK citizen stood in stark contrast to that of the participants, black women and men, living in poverty, whose right to reside in the UK is (for the majority) either in question, or assured on only a temporary basis. Additionally, the participants have all had the experience of an asylum case interview in which the veracity of their words would have been called into question. While there was little I could do to change these inequalities at a structural level, it was crucial that the ways in which I conducted my interviews and related to the participants did not reinforce them. The second concern related to my role as an interviewer and researcher in actively co-creating the research data I obtained (Ormston et al 2013:8; Rapley 2001). Rather than trying to mitigate this by pursuing a role as an 'objective' researcher, arguably both unrealistic and undesirable, drawing as it does on the gendered dichotomy between masculine, objective rationality and feminine, emotional subjectivity (Oakley 1981:31), I

considered it more useful to take stock of the ways in which the research is shaped by both parties in the process. Rapley suggests that instead of understanding the interviewer as a neutral party, it is important to be aware of how the interviewer, as well as the participant, impacts the outcome of the interview (Rapley 2001:318).

These two concerns demonstrate the fundamental importance of carefully considering the relationship between researcher and participant in qualitative research (Lewis & McNaughton Nicholls 2013: 67; Ormston et al 2013:8). There has been considerable discussion about the role a researcher should take in the research process and many perspectives on what the most appropriate relationship is (Rapley 2001:304). The traditional perception of the ideal type interviewer who, although friendly, remains detached, 'objective' and offers as little of him or herself as possible to the interview has been challenged by feminist researchers who suggest that this is not only unrealistic but also 'morally indefensible' since it serves to maintain social hierarchies (Oakley 1981:41). Conversely, an open interviewing style, in which the researcher allows him or herself into the interview and the differences between researcher and researched diminish, not only increases the likelihood that sufficient rapport will be built up for a successful interview, but also provides an opportunity for that hierarchy to start to be undermined (Yeo et al 2013:180). In this way, the interview process can move from being a 'data collection instrument for researchers to being a data collecting instrument for those whose lives are being researched' (Oakley 1981:49), and contribute towards the aim of advancing the interests of those who take part in the research (Yeo et al 2013:181).

A balance must be struck, of course, between being open as an interviewer and answering research participants' questions and directing the research excessively in one direction, or asserting one's opinion in a way that makes participants feel uncomfortable or unable to be open about their own views and experiences. However, conducting interviews with ASRs who are dehumanised in so many of their everyday encounters (Tyler 2013), it was especially important that I engaged on as equal and open a basis as possible. Though I was careful not to express opinions that contradicted the things the participants said to me, I felt it important to answer personal and other questions, as I asked them to open up their personal lives to me. For example, when talking to one participant about engagement in health screening she asked if I had ever had a cervical smear test. Although I did not want to suggest that she should make the same decision as me, it felt appropriate to tell her that I had.

4.2 Research design

My research design was influenced by the practices and principles of ethnography, with the intention of gaining the types of insights that an ethnographic approach can provide. I explore here the principles of an ethnographic approach, and in particular its relevance for the types of questions my research sought to answer. I subsequently describe the components of the ‘focused’ ethnography.

4.2.1 Ethnography

Ethnography, long the central research methodology of anthropology has now been adopted by other social science disciplines and, increasingly, influences applied research as well (Atkinson & Pugh 2005). Rather than a precise set of methods, ethnography can more appropriately be conceived of as an approach to research, in which the intention is to learn about people ‘by learning from them’ (Roper & Shapira 2000 in Cruz & Higginbottom 2013: 37) and gain an in-depth understanding of the social and cultural context of lived experience across a group or collective of people (Bandyopadhyay 2011: 56).

O’Reilly describes the core facets of ethnography succinctly, noting that ethnographic research should be informed by theory that explores the complex ways in which agency and structure interact to shape everyday experiences. Predicated on this, ethnography must examine individual and social life as it unfolds a) in context and b) over time (2012:1). Further, ethnography is a reflexive practice in which the researcher’s own role in constructing and shaping the research must be acknowledged and engaged with (2012:1). Common features of ethnographic research include sustained, long-term engagement, participant-observation and a range of types of interviews (O’Reilly 2012). The precise balance of methods that comprise the ethnography may vary, but the core principles remain.

Ethnographic approaches fit neatly with the orientation of my thesis; both with the disciplinary influences on my research (critical medical anthropology and primary care); and also with the questions I am engaging with, of what it means to be healthy and access healthcare, in the context of being a refugee or asylum seeker from Sub Saharan Africa in Glasgow.

Ethnographic approaches have been employed in critical health research. Seth Holmes conducted research on the healthcare related experiences of migrant Latino farmworkers and the ways in which these are shaped by structural violence. He carried out 18 months of participant observation and in depth interviews, asserting that ‘these multi-faceted long-term qualitative methods are necessary to investigating such subtle and complex social phenomena without simplifying the intricate socio-cultural realities in which they are embedded (Holmes 2012: 875). Similarly, Page-Reeves et al who take structural violence as a lens through which to explore diabetes prevention with Hispanic immigrants use ethnographic approaches to conduct research that is ‘culturally situated and contextually relevant’ (2013a:3).

More recently, other disciplines, including those in the applied health sciences, have come to embrace ethnographic approaches albeit often keeping to shorter time frames or having a narrower focus of enquiry than is traditionally the case. In line with the priorities of primary care research, this thesis uses a focused ethnographic approach.

4.2.1.1 Focused ethnography

A core aim of this thesis has been to explore the extent to which critical anthropological perspectives and methods can be absorbed within the field of primary care, which takes a more pragmatic orientation. In keeping with the principles of critical medical anthropology I aimed to explore experiences of health, wellbeing and service access within a social, cultural, economic and political context, and therefore research methods were required that would help illuminate these linkages. Rather than the longer term and broader engagement traditional in classic anthropology, I felt that a ‘focused’ or ‘micro’ ethnography would be the best way to explore these complex connections in a manner that was manageable for applied primary care research and that was directed towards thinking through solutions for a given problem. The main features of a focused ethnography are described in Figure 2.

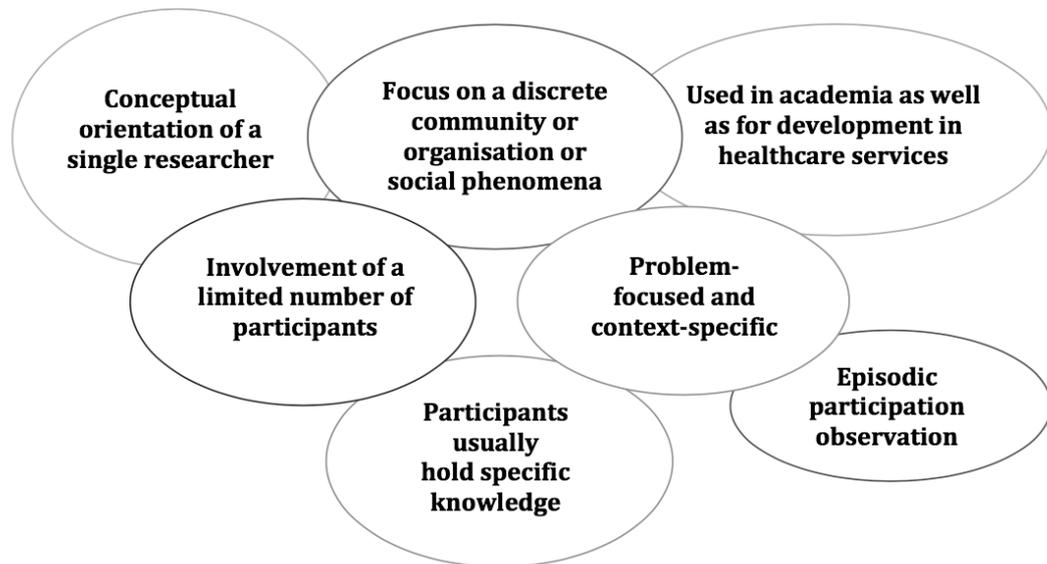


Figure 2: features of a focused ethnography

Higginbottom et al 2013:3, adapted from Muecke 1994

Focused ethnographies, predominantly used in applied research, are characterised by short term field visits, intense data collection and a focus on a narrow element of one's own society (Knoblauch 2005:2-5). Methods for data collection vary, but can include in-depth interviews, short term participant observation, and photo elicitation (Higginbottom et al 2013). Such ethnographies are considered to be a practical and efficient method for gathering in depth and solutions focused data (Higginbottom et al 2013:1). Focused ethnographies therefore provide a useful opportunity to focus on specific issues in particular settings (Cruz and Higginbottom 2013:39). Unlike more traditional ethnographies, focused ethnographies start with specific research questions in mind (Muecke 1994:205). Muecke warns that the narrower focus runs the risk that the wrong questions will be asked (ibid). It was therefore important that I kept my topic guide sufficiently broad so that unexpected issues which might arise could also be explored and incorporated into my data collection.

Unlike traditional ethnography which has emphasised travelling to a far away location in order to immerse oneself in an "other" culture, focused ethnographies have tended to explore aspects of culture present in one's own society (Wall 2015:3). In a focused ethnography participants are not necessarily part of a cohesive community, but share common characteristics or experiences. This was appropriate for my research which engaged in fieldwork 'at-home' rather than away. In my case, the particular setting was the

context in which African refugees and asylum seekers accessed healthcare and sought to keep themselves healthy in Glasgow. Though my field of enquiry may have been narrow, the sort of questions pertinent to the research were, I felt, best explored with an ethnographically inspired approach. Table 4 provides examples of focused ethnographies in health research.

Paper	Aim	Sample/Setting	Methods	Results/Conclusions
Gerrish et al 2013	To explore Somali patient and healthcare professionals' perspectives on tuberculosis diagnosis & management	14 Somali patients diagnosed with TB & 18 professionals who care for them in the UK	Individual in-depth interviews	- Limited awareness in primary care leads to diagnostic delay -Nurses have role in awareness raising in the Somali community
Gagnon et al 2013	To explore how migrant women respond to maternal-child health issues & determine what interventions are most appropriate to facilitate maternal-child health	16 immigrant women residing in Montreal or Toronto, who had previously been identified as having a high psychosocial risk profile	Participant observation & in-depth interviews	- Women drew on many different methods to respond to maternal-child health issues - Social inclusion is critical in enhancing resilience for all mothers
Plaza del Pino et al 2013	To elicit nurses perceptions on intercultural communication with Moroccan patients	32 nurses across three public hospitals in Southern Spain	Semi-structured interviews	Barriers related to language, prejudice and 'social stereotypes' affect communication between nurses and Moroccan patients
Taylor et al 2015	To look at the experiences of nurses caring for older adults in emergency departments	Seven nurses working in a tertiary care hospital in an urban centre in Canada	Semi-structured interviews and non-participant observation	Older adults do not fit into the 'culture' of the emergency department and so receive sub-optimal care

Table 4: Examples of focused ethnographies in health research

4.3 Research design and development

Section 4.3 details the design and process of the focused ethnography which was conducted in Glasgow. The ethnography was comprised of three phases: I first engaged with ASR community organisations in order to learn more about ASR provision and needs in Glasgow. After this I ran a series of focus groups, facilitated by the community organisations, where I used the participatory research tool Ketso, as a means to talk about experiences of keeping healthy in Glasgow. The third phase involved semi-structured and walk-along interviews with ASRs (many of whom had participated in a focus group), as well as public health and primary care professionals. The components of the focused ethnography are summarised in Figure 3.

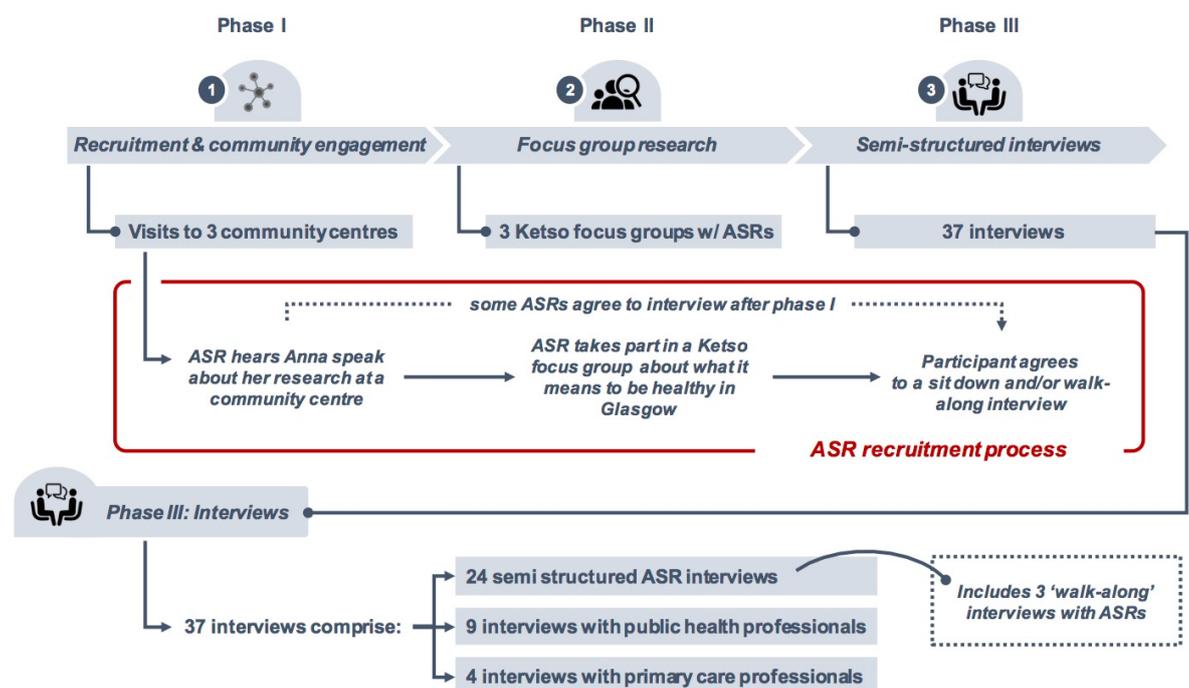


Figure 3: components of focused ethnography

4.3.1 Field site

The focused ethnography was conducted across several community organisations, GP surgeries, public health departments, and private homes in Glasgow. There was no one cohesive field site, but a variety of spaces where the participants lived, worked, and engaged with the community. All participants either lived or worked in Glasgow, but there was no narrower geographical boundary.

4.3.2 Sampling and recruitment

Sampling:

The sampling strategy took the form of *purposive sampling* in which participants were chosen because they matched specific characteristics that would enable my research questions to be answered (Ritchie et al 2013:113). For the professional interviews I was keen to recruit individuals with a range of different roles, located across the city, but focused on primary care or public health. The sampling criteria for my ASR participants were equally broad. I intended to recruit individuals from Sub Saharan Africa from both genders and across a range of ages who spoke English. However, during the course of the research it became clear that there were increasing numbers of asylum seekers from Eritrea making their home in the city. I was keen that this national category be included in the research despite the fact that many did not speak English and so I sought the assistance of an interpreter and expanded my inclusion criteria. ASR participants were sampled until data saturation was reached and no new information was being elicited during the interviews (Gentles et al 2015:1781). The intention of the public health and primary care interviews was to provide illustration and additional context and so the number of interviews was considered to be less relevant.

Type of interview	Number of interviews	Notes
Public health practitioner	9	<i>* All but three individuals who took part in the focus groups also took part in an interview</i>
Primary care practitioner	4	
Refugee/ asylum seeker	24	
ASR focus group	16*	

Table 5: Interview numbers by type

Public health recruitment:

Initial recruitment efforts in public health involved taking recommendations from the Director of Public Health at NHS Greater Glasgow and Clyde (NHS GGC) on the public health consultants working in the field of refugee and migrant health. One consultant was recruited through this route. Subsequently, through attending meetings on migrant health in Glasgow and contacting individuals involved in specific refugee/ migrant health projects, a further eight individuals were recruited for interview, seven of whom worked for NHS

GGC and one who worked at a community health organisation. I made initial contact with potential participants by email, providing a brief explanation of the research and attaching a participant information sheet.

Primary care recruitment:

Recruitment in primary care proved the most significant challenge, perhaps due to the extent to which GP practices are overburdened with routine demands and the fact that many surgeries see few if any ASR patients. While many researchers are able to pay doctors to compensate for clinic time, this was beyond the scope of my PhD funds. Nevertheless, I was able to interview two GPs, one primary care nurse and one pharmacist who works in a primary care setting. Contact with these individuals was made on the recommendation of colleagues based at General Practice and Primary Care, University of Glasgow and took the form of an email with attached information sheet.

ASR participant recruitment:

The bulk of my fieldwork involved interactions with my refugee and asylum seeker participants. Recruitment of these individuals for both the Ketso²² focus group sessions and interviews came directly out of community engagement. This is described in detail below in the section on the process of conducting the focused ethnography.

(See appendices for participant recruitment material)

4.3.3 Ethical approval

Ethical approval was sought and obtained from the University of Glasgow MVLS college Research Ethics Committee. Additionally, because the study involved NHS health professionals (both in public health and primary care), NHS research and development approval was required. The fieldwork study was sponsored by the NHS Greater Glasgow and Clyde Health Board (NHS GGC)²³.

²² Ketso is a participatory research tool described in detail below

²³ See Appendices A-I for ethics approval for consent forms, participant information sheets, topic guides, and recruitment material.

4.3.4 Conducting the focused ethnography

The three distinct, but overlapping, phases of the focused ethnography were conducted between December 2014 and December 2015. The first, which took place over the entire time-period involved engagement with community groups. The second phase comprised the Ketso focus groups, and the third, in-depth semi structured interviews with ASR, public health, and primary care participants.

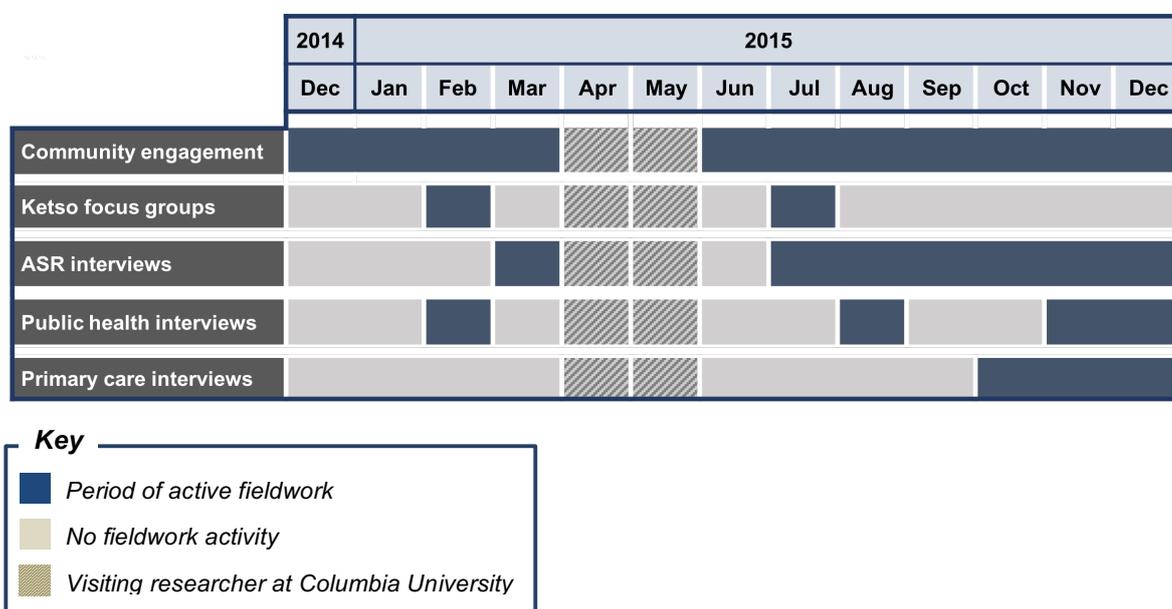


Figure 4: fieldwork timeline

4.3.4.1 PHASE 1: Community engagement

As the largest part of my fieldwork involved working with ASR participants, the process of fieldwork commenced with a period of community engagement. I started by contacting a number of religious, community, and third sector groups whose clientele, or ‘group’ they engage with, included ASRs from Sub Saharan Africa. I met with the leaders or staff members of various groups to explain my proposed research, emphasise my desire to undertake a project that engaged the community, and importantly, seek their advice on ensuring that my research was relevant and appropriate. I attended a variety of different events, including church services and ASR advocacy groups and visited numerous organisations that engage with refugees and asylum seekers from Sub Saharan Africa. While not all of these engagements resulted in actual research opportunities, it did provide me with an opportunity to see the breadth of organisations that engage with refugees and asylum seekers in Glasgow and better understand the various sources of support that are available. Crucially, attending these groups allowed me to meet with potential research

participants in a setting in which they were comfortable, explain the research I was doing, and answer any questions.

Whilst every organisation I met with was broadly positive about my research intentions, community engagement takes a considerable amount of time, and can result in many false starts. A number of my recruitment efforts, though they seemed promising at first petered out without any actual research taking place, whereas others that might have initially seemed less reliable ended up providing rich sources of engagement. Recruitment challenges are perhaps unsurprising given that I was seeking engagement with third sector organisations that are overburdened, have limited resources, and face significant funding constraints, and participation from individuals whose lives are precarious and often unpredictable. Certainly, recruitment efforts required a good deal of flexibility, openness, and perseverance.

Over my year of fieldwork, I was able to establish a longer term engagement with three groups in particular: 1) a third sector organisation that runs a number of programmes with refugees and asylum seekers, 2) a health charity that regularly engages with Sub-Saharan Africans, and 3) an African community centre. At these three organisations I was given the opportunity to recruit participants, and, in the case of the first two, a physical location to run focus group sessions. While I did not engage in formal participant observation, spending time in these settings allowed me to gain deeper insight into the various contexts of the participants' lives and, crucially, start to establish rapport. At Organisation 1, I attended a number of their monthly asylum seeker and refugee advocacy group meetings where I was provided time to speak to group members about my research. They then had the opportunity to ask me any questions and provide me with their contact details if they were interested. At Organisation 2, Aman (anonymised), a member of staff, described my research to the refugees and asylum seekers he worked with, and assisted me in arranging focus groups. At Organisation 3 I was introduced to drop-in attendees and given the opportunity to tell them about my research. I left a research poster with my contact details at all three locations. Ethnographic methods require a level of flexibility that might be unexpected for an applied health researcher. During periods of data collection, I often had only a few hours notice that a participant was available for interview, or that a focus group had been organised.

Following community group engagement, I commenced the formal research process by arranging Ketso focus groups. I felt this would be an appropriate way to introduce myself

to participants further and they could then decide if they were willing to participate in more in depth interviews. It also allowed me to gather contextual information about the experience of living in Glasgow before seeking more in-depth personal and health related information. In total I arranged three focus groups with six, three, and seven participants respectively (three men and 14 women). At the end of the focus group session, I asked if participants might be willing to participate in an interview, though I stressed that there was no obligation to do this. All but three focus group participants agreed to take part in an interview and provided me with their phone numbers to arrange this. Additionally, I invited participants to provide my contact details to friends who might also be interested in taking part. Through this snowballing process, and with assistance from Aman, I recruited an additional ten individuals to participate in an interview, making a total of 24. 17 of the participants had either fluent or conversational English but seven, six of whom were from Eritrea and one from the Sudan, required the assistance of an interpreter. As I was keen to maintain engagement with the organisations I was involved with, Aman, who worked at organisation 2, but was also a refugee from Eritrea himself, assisted me as an interpreter. I sought additional ethical approval for this.

4.3.4.2 PHASE 2: Participatory mind-mapping

The three focus groups took the form of a participatory workshop, using the research tool Ketso (www.Ketso.co.uk). Ketso, meaning ‘action’ in Sesotho, was developed as a participatory ‘mind-mapping’ tool by academics at the University of Manchester (Tippett 2007; Tippett 2009) as a means to encourage active and creative participation in research. Rather than being led by the researcher, it is the participants who determine the contents and direction of the focus group (ibid). It can be used in myriad ways, but is supposed to encourage individuals to think about the different facets of a question or problem, culminating at the point where participants consider what they themselves might be able to do about it. The Ketso kit is imbued with metaphors about nature and contains a felt background board, washable plastic leaves to write ideas on, and branches to link the leaves together. The leaves come in four colours, with each colour representing a different aspect of a question:

Colour	Metaphor	Meaning
Brown	Soil	What works or what exists already
Green	Shoots	Future possibilities
Grey	Rain	Challenges
Yellow	Sunshine	Goals

Table 6: Explanation of Ketso leaves

The topic of the workshop is stuck at the centre of the felt and the leaves are used to consider different aspects of the topic. Participants are first provided with brown leaves and progress through green and grey, finishing with yellow over the course of the workshop. The colour progression is intended as a way to structure each person's thoughts. Ideas, which could take the form of a word, sentence, or picture, are written on the leaves and stuck onto the felt board in the style of a mind map. There is a strong emphasis on ensuring that all participants are able to participate equally, so the motto at each stage is 'think then share'. Each participant spends some time in silence writing their ideas down on as many leaves as they need (one idea per leaf) and then take it in turns to explain their ideas and stick them down on the felt. Ideas might start to be clustered on the board around particular themes.

Ketso thus fits well into a research paradigm that is seeking to interrogate or undermine power relationships in research, because although the Ketso session is led by the researcher, the ideas are very much generated by the participants who determine the direction that the session progresses in.

Conduct of the Ketso sessions:

Prior to running the Ketso sessions for the ASR participants, I developed in-depth knowledge of Ketso both through being a participant in two Ketso sessions (on unrelated topics) and through running a pilot session in my university department. In this pilot session I was able to gain a better feel for how best to facilitate the session and where questions or concerns might arise. I used the same theme in this pilot session as in the formal fieldwork sessions.

Group	Number of people
One	6 women
Two	7 women
Three	3 men

Table 7: Participants in each Ketso session

The Ketso kit is extremely versatile, and the questions represented by my leaves differed slightly from those listed above. The central theme to be explored at each session was ‘Is Glasgow good for my health?’, with each leaf representing a different aspect of that question. Participants could write on the leaf in any language they chose, or alternatively draw a picture.

I divided the question into four smaller questions which were intended to draw a broad picture both of what health meant to the participants and how this was experienced in Glasgow. These were:

Brown leaf: what influences health?

Green leaf: what is good about Glasgow (from a health perspective)?

Grey leaf: what is bad about Glasgow (from a health perspective)?

Yellow leaf: what improvements can/ should be made?

At the start of the session I outlined the principles of Ketso, highlighting in particular the ‘think then share’ principle and emphasising that it was ok to write just one word, or a picture instead of a sentence (or indeed write in another language). I explained that I was interested in exploring their feelings about Glasgow and whether they felt that they were able to lead healthy lives here. The session started with the brown leaves (what is important for keeping healthy in general) and progressed to consider their lives in Glasgow more specifically, in particular the ways in which they thought the city impacted on their health. I stuck some initial themes onto the Ketso board as a starting point, based on the discussions generated in the pilot session, which I revealed after they had considered the first question. However, these themes were altered and new ones developed over the course of the session. In the first session, for example, the asylum system became a theme in its own right.

The discussions generated by the session were recorded onto two audio recorders and transcribed verbatim. Additionally, the final Ketso boards were photographed and the contents of each leaf were copied into a table²⁴.



Figure 5: a KETSO board in progress

It is impossible to ensure that every individual around the table is able to contribute on an entirely equal basis. However, the principle of ‘think then share’ is extremely helpful in ensuring that the final board is reflective of the feelings of the whole group. Given that English levels in the group varied, the opportunity to just write one word, or draw a picture on the leaves was also helpful. In general, the participants seemed interested in the idea of Ketso and enjoyed the novel experience of writing/ drawing on the plastic leaves, with one participant stating that she didn’t want to write on ‘normal’ paper again. At the end of the Ketso session I asked whether individuals would be interested in taking part in a further interview. All but two agreed and I collected their contact details so I could provide more information about the interviews.

4.3.4.3 PHASE 3: Interviews

The second phase of the focused ethnography involved in-depth semi-structured interviews. I conducted these with i) African refugees and asylum seekers; ii) public health professionals and iii) primary care professionals together with walk along interviews with those refugee and asylum seeker participants who were interested. In total I conducted 24 refugee/asylum seeker interviews, three of which also included a walk-along component, 9 public health interviews and 4 primary care interviews.

²⁴ See Appendix K for an example of a table

At the beginning of each interview I went through the participant information sheet with participants, stressing that they were free to withdraw from the research at any point. I also provided a consent form for us both to sign. With the permission of participants, all interviews were recorded onto an Olympus digital recorder and uploaded into a password protected file. All interviews were transcribed verbatim by a transcription company and then checked over by myself to ensure accuracy and anonymity. Anonymised transcripts were then uploaded onto the qualitative research software NVIVO for analysis. I also carried a field diary to note down thoughts and observations immediately after the interview.

(see appendices for participant information sheets and consent forms)

Semi-structured interviews:

With all my interview groups, the sit-down interviews took the form of semi-structured interviews, in which I had a loose topic guide but allowed the interview to be driven by the interests and perspectives of the participants. Indeed, rather than a formal process, a semi-structured interview is intended to take the form of a conversation in which the interviewee and interviewer co-create the knowledge that is obtained (Yeo et al 2013:179). This format is useful in ensuring that the researcher is able to cover the topics that they deem to be pertinent to the research, while also allowing the perspectives of participants to be foregrounded (Galleta 2013:2). It also allows an opportunity for power imbalances to be redressed since the interviewer can take their cue from the participants about how actively to be involved (Yeo et al 2013:181). The topic guide for the interviews was developed following a review of the literature on ASR health and conversations with community group leaders.

I was keen to interview participants wherever they would find it most comfortable and convenient. 13 interviews took place in participants' homes, one in a community centre, and the final ten in cafes. The three walking interviews took place in the immediate locale of the participants' homes. Interviews with public health and primary care staff took place in individuals' places of work, with the exception of two primary care interviews that took place in a meeting room in General Practice and Primary Care, University of Glasgow.

I was often surprised by how warm and open the participants were in telling me the stories of their experiences in the UK and beyond. Indeed, these interviews (in particular those

with other women and those conducted in people's homes) often felt more like conversations with old friends than formal interviews and the depth of information they offered me reflected this.

Interpreted interviews:

Glasgow has recently seen a significant increase in the number of Eritrean refugees, in particular young single men. This presented additional challenges in that the majority have extremely limited English. Although conducting an interview with an interpreter significantly changes the interview process, I was keen not to exclude their experiences from my research on these grounds. I therefore decided to employ an interpreter to assist me in conducting these interviews. Aman, who acted as a key informant, was familiar with my research aims and is an Eritrean refugee himself. He was therefore well placed to access and engage these individuals who were in perhaps the most marginal position of my research participants. Prior to recruitment of participants I had my participant information sheets and consent forms translated into Tigrinya (the national language of Eritrea) by an independent translation company. The interpreted interviews ranged from ones where the participant spoke entirely in Tigrinya to others that involved a mixture of English and Tigrinya according to the questions being asked. Conducting an interview where there is no shared language and a third individual mediating presents significant challenges, particularly around building rapport (O'Donnell et al 2007) and I found it very difficult to gauge how the participants were feeling during the interviews. On a personal level, it provided a clear taste of not just what it might be like to exist in a situation in which every communication is a challenge, but also the difficulties that medical professionals encounter in trying to carry out effective consultations in interpreted settings.

Walk-along interviews:

In concert with my intention to engage in research methods that explore the context in which health is engaged with, I sought to include walking or 'go-along' interviews as one of my methodological tools. This is a qualitative, participatory method that involves accompanying research participants on a walk around their local neighbourhood, or other area they frequent (Carpiano 2009: 264; Garcia et al 2012: 1397) so as to gain an understanding of the context in which health and wellbeing are experienced, while it is being experienced (Cattell et al 2008: 546; Carpiano 2009:265-6). It aims to elicit similar forms of information that might be sought from long-term ethnographic engagement and

allow for the establishment of a theoretical understanding that has a strong grounding in the lived experience of one's research participants (Carpiano 2009:263).

Walking interviews have become increasingly popular as a means to provide a richer source of data than might be expected in a traditional sit-down interview (Evans and Jones 2011: 849). Within a research paradigm that considers the centrality of place in shaping our lives and identities, (Popay et al 2003:56), walking interviews allow a researcher to actively consider how place influences an individual's perspective on health and wellbeing and explore how individuals construct the world around them, as they are in the actual process of moving through that world (Anderson 2004: 255). This is important, since not only does it allow for an examination of the explicit link between place and notions of health and wellbeing, but the very process of experiencing a place can spark thoughts and ideas that might not have surfaced during a sit-down interview (Evans and Jones 2011: 849)

In addition to the type of information that can be elicited, the walking interview method also provides a useful opportunity to subvert the power dynamics that underpin traditional interviewing. While it is usual for qualitative researchers to contextualise interview findings, in the case of a walking interview this contextualisation is done by the active involvement of participants themselves (Garcia et al 2012: 1395). Importantly, instead of a researcher leading an interview and prefacing their own interests, in a walking interview the participants act as guides, directing the researcher to those places that they deem to be relevant to their experiences (Carpiano 2009:267). This can increase rapport and a sense of legitimacy and be particularly useful when conducting research with groups who might have been marginalised or where there are particular disparities between the researchers and participants (ibid).

As noted above, an aim underlying much ethnographic research (and the research in this thesis) is to explore the dynamic ways in which structure and agency interact to shape human experiences. Walking interviews are a useful method through which to engage in this enterprise as they enable us to draw links between the ways that individuals' understandings and experience of spaces and structures shape their understandings of themselves and what their roles are (Carpiano 2009:264).

During the fieldwork, I was only able to conduct three walking interviews. The weather in Glasgow was often not conducive to walking and I felt I could not ask the participants to

accompany me in gale force winds and rain. Additionally, many of my female participants had young children at home making it impractical. It was pointed out to me by one of the participants, that she was already very observable (and observed) in the area she lived in and that it would draw unwarranted attention and questions for her to be walking around with myself as a young white woman. Lastly, what was quite clear from the discussions I had with many participants was that the geographies of their lives did not correspond with the geography of their local area. This was less the case for those women who had children attending local schools, but for many participants, aside from attending a GP surgery locally, most of their activities took place outside their immediate locale, and had them spending much of their days on buses across the city, attending community groups, churches, visiting friends, etc. It was clear that a 'go-along' interview that truly captured the relationship between health and place in their lives would have had to encompass far more than just the immediate neighbourhood. This finding has important implications for the effectiveness of place-based interventions for refugees and asylum seekers in Glasgow and it is crucial to consider how place is experienced for different individuals in different contexts.

4.4 Analysis

Fieldwork data collection gathered over 600 pages of interview transcripts, together with field diary notes and photos of the completed Ketso boards. Although both the research questions and methods were theoretically informed, I chose to conduct a thematic analysis without any a priori theoretical framework as I was keen to ensure that I did not unwittingly exclude data that did not fit in with my pre-conceived ideas (Ziebland & McPherson 2006:405). I was keen however to engage in a thematic analysis that went from being description to analysis and explanation (Spencer et al 2013: 279).

The analysis followed a two-stage process, the first of which involved organising, indexing and categorising the data and the second of which involved abstraction and analysis (Spencer et al 2013; Ziebland & McPherson 2006). In practice, these two stages are not entirely distinct as analytical considerations come into play as soon as data immersion begins.

4.4.1 Data organisation

The formal analytic process commenced at the point at which 50% of the fieldwork was complete, though an informal process began at the outset. Transcripts were read and reread in a process of data ‘familiarisation’ and immersion (Spencer et al 2013:282) and initial observations on the data, together with emerging categories and sub-categories were noted down. At this stage these categories were organisational rather than analytical (e.g., ‘access to health services’, ‘language’). After an initial coding framework was developed, all transcripts were uploaded to the qualitative research software NVIVO and coded according to the framework (i.e., different parts of the transcripts were collected under different themes). This coding was an iterative process with more codes being added as the analysis progressed²⁵.

Once all the data had been coded according to the framework, a coding report was printed for each category. The data collected under each category was reread multiple times so that I could develop a clearer understanding of the breadth of topics within each category, and the similarities and differences between different participants’ responses (Spencer et al 2013:282). At this point I arranged a series of ‘coding clinics’ with my supervisors to discuss the emerging topics and themes. Having broadly agreed with the themes I developed, my three supervisors and I all coded one interview transcript to ensure that the data was being interpreted in a uniform way.

At this stage, I also anonymised all of the participant data. I chose to give the participants pseudonyms, rather than codes, so as to keep their humanity in the foreground. I chose names that were common in each participant’s country of origin.

4.4.2 Data analysis

Having reread the themes multiple times, I followed Ziebland & McPherson (2013) in developing a ‘One Sheet of Paper’ (OSOP)²⁶ analysis for each of my categories. In this process, a sheet of A4 paper is assigned to each category and all the emerging themes in each category are mapped out on each sheet of paper (Ziebland & McPherson 2006:409). In these OSOPS I considered how each subtheme related to each other, explored the diversity of responses to a different topic and tried to draw an overall picture of each

²⁵ See Appendix L for development of coding framework

²⁶ See Appendix T for an example of a finished OSOP

category. At this stage I engaged in regular discussions with my supervisors about the content of the OSOPs. It was important to note which participants had which perspectives, so as to see if any commonalities could be drawn between participant characteristics and their responses across themes. Just as important as looking at the similarities across themes is exploring outlying cases and considering their meaning (Ziebland & McPherson 2006:409). In creating these OSOPs, a pathway is provided from simple categorisation of the data to a more complex analysis.

Having ascertained the main research themes, it was possible to return to the theoretical framework to explore how other perspectives might illuminate the qualitative results (Ziebland & McPherson 2006:409). Therefore, having considered the results on their own first, I returned to the theories of candidacy and structural vulnerability to examine how useful they might be in elucidating my data. I looked at the extent to which perspectives on health, access to care, and preventive practices fitted within the candidacy framework and considered the extent to which structural vulnerability illuminated the context in which these practices took place.

4.5 Research Questions

In this chapter, I have presented the rationale for my data collection and described my methods of recruitment, data collection, and analysis. Prior to progressing to the results section of this thesis, it is useful to recap on the main research questions being asked in the ethnography.

1. What does being 'healthy' mean to asylum seekers and refugees from Sub Saharan Africa in Glasgow?
2. What are ASR experiences of using primary and preventive health services?
3. What impacts on ASR capacity to keep healthy and access healthcare services?
4. How do health professionals in Glasgow talk about refugee health and access to care?

Chapter Five: Introduction to the results

5.1 Layout of the results

Chapters Five, Six, Seven and Eight discuss the results of the focused ethnography: the community engagement, Ketso groups, and semi-structured and walk along interviews. I present the results at two different levels: 1. individual-level perceptions and experiences of health, prevention and service engagement and access; and 2. the role of the ‘environment’ in which perceptions are formed and engagements take place. It is impossible to talk about individual and structural level factors in total isolation, and indeed it is the central theoretical underpinning of this thesis that there is a symbiotic relationship between individual experiences and structural context. For simplicity of presentation however, chapters six and seven consider predominantly individual experiences, which are then contextualised in chapter eight. Though the primary focus of the results is the experience of the asylum seeker and refugee participants, I also reflect throughout, on the opinions of the primary care and public health professionals interviewed in my study.

Chapter Six of the results draws on the candidacy framework (Dixon Woods 2005) to consider the ASR participants’ perceptions of what it means to be ‘healthy’, what causes illness, and what health practices might be useful in preventing it. This is paired with the perspectives of professionals in public health and primary care. How do they conceptualise risk for this group, and what do they consider to be the most significant health concerns for refugees and asylum seekers? Where is there concordance, and where do expectations differ?

Also utilising the candidacy framework, Chapter Seven proceeds to experiences of, and engagement with formal services, specifically, primary and preventive healthcare, and social support. How do ASRs feel about the healthcare system in Scotland? What are the barriers and facilitators to access and optimal use? Again, the professional perspective is also considered here.

In chapter seven, I move to the broader environment in which these health-related experiences play out. Here, employing the theory of structural vulnerability, I seek to elucidate not just the determinants of health and wellbeing for the participants, but also the determinants of their perceptions of health and wellbeing. I consider also, the extent to which professionals take these into account.

Lastly, in Chapter Eight, I draw these two theoretical perspectives together, to consider the utility of candidacy as a framework through which to understand ASR experiences of preventive care. Drawing on my fieldwork data I develop a modified version of candidacy in which the relationship between the micro- and macro-level is made explicit at each stage, and in which preventive care fits more easily.

This chapter sets the scene for the following chapters by describing the setting, the participants and – most importantly – giving a flavour of the complex stories that exemplify the experiences of the participants as they transitioned from their own country to living in Scotland. I additionally consider some overarching narratives that presented throughout the ASR interviews.

5.2 The field site(s)

As previously described in Chapter Four, there was no one ‘field site’ that defined my research, but a collection of homes, community centres, cafes and workplaces across Glasgow. Following the privatisation of asylum accommodation provision in 2012, asylum seekers are now dispersed across the city, and those who are refugees are housed in the same way a native Glaswegian would be. My formal research first started at two community centres and a public health charity where I conducted the Ketso focus groups and met potential participants. Here I was able to experience some of the activities the participants were engaged in, such as asylum support groups, a choir, and a community run barber shop. From these sites, the research moved out into the participants’ homes, cafes, and neighbouring environments. Interviews with health professionals were all conducted at their place of work, apart from one where the interview took place in the offices of General Practice and Primary Care, University of Glasgow.

Although the participants all resided in relatively deprived areas of the city, the neighbourhoods and homes they lived in varied markedly. I visited traditional tenements, high rise apartments, and new builds; areas where ethnic minorities were few and far between, and areas that had a high degree of ethnic diversity; neighbourhoods where shops, parks and other amenities were easily accessible and those that were more isolated; homes where the participants shared their living space with a stranger, and others where a couple, or a mother with her children lived together. I met some participants in a café close to the centre of town. For some participants this was easier because they had other engagements in town during the day; for others, the additional requirement of an

interpreter made it more practical logistically. The participants were extremely generous with their time, and those I met in their homes were keen to offer me teas, coffees and in one case, homemade bread.

5.3 The participants

In total I conducted interviews with 24 individuals who were refugees and asylum seekers, 13 of whom also took part in a focus group. Three extra individuals took part in a focus group, but did not have an individual interview. Table 8 provides demographic information about these ASR participants. I also interviewed eight public health professionals and four individuals who worked in primary care (two GPs, one pharmacist, and one nurse). My asylum seeking participants were a diverse group. Although all had come from Sub Saharan Africa, and all shared the experience of being a refugee or asylum seeker in Glasgow, they varied in many ways, including age, gender, country of origin, health status (both physical and mental), whether they had children, whether they were here with a partner, their experiences before arrival in the UK, and the extent to which they were willing to share those experiences. While some participants opened up to me with minimal prompting, others were more interested in talking about the situation they found themselves in at that particular moment and did not focus on their past.

In my interviews with public health and primary care professionals, I asked similar questions to those I asked the ASR participants in order to ascertain the extent to which view points were concordant or discordant. Although much of these conversations centred on service use, or provision, equally relevant were discussions about what sorts of illnesses African refugees and asylum seekers might be most at risk of. Some of my professional participants had a specific interest in refugee health whereas others simply worked in areas where there were sizable ASR populations. Although the numbers of people from Sub Saharan Africa living in Glasgow has increased exponentially over the past 15 years (CoDE 2015), they were not considered a significant community in Glasgow, in comparison, for example, to the South Asian community who were seen to have very specific health needs. Public health and primary care professionals were significantly more likely to have considered the refugee/ asylum seeker aspect of the participants' identities.

Name	Age	Sex	Time in UK	Marital Status	Religion	Country of birth	Previous job	Current job
Asylum seekers								
Hagos	20-29	M	1 year	Married	Muslim	Eritrea	Mechanic	n/a
Priscilla	30-39	F	9 years	Married	Christian	Malawi	Banker	n/a
Asmeret	30-39	F	7 months	Single	Orthodox Christian	Eritrea	Housemaid	n/a
Thandi	30-39	F	10 years	Divorced	Christian	Zambia	Pre-school assistant	n/a
Fikru	30-39	M	10 years	Single	Christian	Eritrea	Soldier	n/a
Robel	30-39	M	7 years	Single	Christian	Eritrea	Shopkeeper/soldier	n/a
Elizabeth	40-49	F	12 years	Married	Christian	Zimbabwe	Hotel manager	n/a
Mufaro	40-49	F	8 years	Single	Christian	Zimbabwe	Teacher	n/a
Azzam	40-49	M	11 years	Single	Christian	Ghana	Civil engineer	Student
Tadesse	40-49	M	1 year	Married	Muslim	Eritrea	Soldier	n/a
Brenda	50-59	F	11 years	Widowed	Christian	Malawi	Teacher	n/a
Tadiwa	50-59	F	13 years	Divorced	Christian	Zimbabwe	Teacher	n/a
Audrey	60+	F	14 years	Widowed	Christian	Zimbabwe	Fashion designer	n/a
Esther	60+	F	8 years	Single	Christian	Zimbabwe	Self employed	n/a
Refugees								
Birhan	20-29	M	8 years	Single	Christian	Eritrea	Student	Food quality controller
Fessehaye	20-29	M	5 years	Single	Muslim	Eritrea	Soldier	Unemployed
Hazel	30-39	F	9 years	Single	Christian	Zimbabwe	Hair salon owner	Unemployed
Mebrahtu	30-39	M	1 year	Single	Christian	Eritrea	Soldier	Unemployed
Osman	30-39	M	4 years	Single	Muslim	Sudan	Musician	Student
Joseph	40-49	M	12 years	Married	Christian	Zimbabwe	Teacher	Housing assistant
Awo	40-49	F	12 years	Single	Christian	Ghana	Farmer	Care assistant
Mercy	40-49	F	7 years	Single	Christian	South Africa	Chef	Unemployed
Nesta	40-49	F	12 years	Married	Christian	Zimbabwe	Sales rep	Specialist radiographer
Melissa	50-59	F	10 years	Single	None	Zimbabwe	Teacher	Unemployed

Table 8: ASR participant demographics

5.4 Participant stories

The ASR participants came from a diversity of backgrounds in terms of their countries of origin, their experiences in Glasgow and their family and social set up. The data in this thesis convey only one small aspect of their existence. I therefore share here more detailed stories of three of the participants, to provide a broader view of their lives:

“We go through like maybe a lot of stress with the Home Office and stuff and I end up not prioritising because of that. Because I’m trying to focus on that and then when I start focusing on Home Office issues everything else just falls to the side.” - Priscilla

Priscilla is an asylum seeker from Malawi and lives in an area of Glasgow that houses a considerable number of people from Sub Saharan Africa. She lives in an apartment in a poorly maintained block accessed by an external staircase, and expresses embarrassment about the state in which the building is kept. She was housed in the Red Road Flats²⁷ prior to the privatisation of asylum housing provision, and feels a sense of loss for the community of asylum seekers she had there. Her current neighbourhood, though run down, has good transport links to other parts of the city, and decent access to supermarkets, shops and green space. She is married, lives with her three school-aged children, and is actively engaged with a number of refugee organisations in Glasgow. She has been fortunate to avail herself of academic funding for asylum seekers and is completing a postgraduate degree. Her life is, nevertheless, punctuated by the monthly visits she must make to the Home Office where her asylum claim is still under consideration. As an asylum seeker, she is regularly required to supplement her groceries with staples from the food bank, the quality of which concerns her. She expressed awareness about her health – she suffered from gestational diabetes during her third pregnancy and her young daughter is overweight, and she is aware of the necessity of good diet and exercise in mitigating such concerns. However, she finds it very challenging to balance these priorities with her limited income, and the other pressures on her life.

“The power is in their hands.” - Elizabeth

²⁷ See footnote p.162

Elizabeth and her husband came to the UK from Zimbabwe without their children, and lived in Dundee for several years before coming to Glasgow. She spoke in detail of her extreme loneliness while living in Dundee, which has somewhat abated since moving to Glasgow, where opportunities for community engagement are more plentiful. While her husband has recently had his asylum claim accepted, Elizabeth is still awaiting a response. It is causing a good deal of concern that her husband has received his papers, while she has not. Her feelings of lack of control over her future merged into discussions about how she felt unable to control her health. She mentioned the weight she had put on since moving to the UK, and contrasted the idealized Zimbabwean female body with the idealized Western body. The area in which they are housed has few ethnic minorities and appears very desolate, with a broken playground and few individuals around. She spends as little time in her neighbourhood as possible, largely travelling between her house and the bus stop that takes her into the centre of town. She expressed concerns about the safety of the neighbourhood as being a factor in her limited use of the area. She has little reason to frequent the area, however, since the individuals and community groups with whom she engages are all based elsewhere. Following a road accident, Elizabeth had a very unsatisfactory engagement with health professionals in an A&E department who did not believe her account of what happened. This has left her with enduring physical symptoms, as well as highly distrusting of doctors who she felt had acted in a racist manner.

“To me it seems to be like the health professionals they don’t understand asylum seeker and refugee, they don’t understand our problem and our financial issues.” - Mebrahtu

Mebrahtu is a young man from Eritrea who has been in the UK less than a year. He is impressed by the friendliness of the city, but is aware of cultural tensions between what he considers to be his own moral norms and those norms that prevail in Glasgow (e.g., drinking, dating women etc.) and has concerns over how to find a balance. He suffered from numerous health problems in Eritrea which were exacerbated by his time in enforced conscription in the army. Emphasising how little the Eritrean regime cared about individuals’ lives, he expressed the hope he had had, that his health issues might be addressed on arrival in the UK. However, so far this hope has not been borne out, with a series of unsatisfactory, interpreter mediated secondary care consultations leading him to lose trust in the opinion of medical professionals. Although he is due to have an operation,

he is no longer convinced that this is a sensible course of action. He considers his medical conditions, together with the financial constraints placed on him as an asylum seeker, as limiting his ability to live in a way that would allow him to be 'healthy'.

5.5 The all-pervasive experience of being a migrant

As noted above, while Chapters Six and Seven take a broadly individual level perspective, Chapter Eight focuses on the structural aspects. There are however two pervading narratives related to the migrant experience that colour the following three chapters, sometimes implicitly, and sometimes more overtly.

First, even when focusing purely at the individual level it was evident that the narratives the participants presented to me were couched in the context of what they had experienced throughout their lives. Pre-, during- and post-migratory experiences were central to the ways in which the participants understood both themselves and their health. As a result, health related events were often described alongside key events in their personal biographies.

Melissa (f, 50-59, Zimbabwe, refugee) had been living with type II diabetes for a number of years. She described the ways in which she managed her diabetes as connected to the challenges she faced as a newly accepted refugee, trying to find work, complete a university degree, and pay her rent. In this case, she became locked in a vicious cycle, since the poorer her diabetes control, the less she was able to manage the rest of her commitments.

“Yeah, so there was too much pressure on me. At the end of it, if you've got such a massive pressure on you, you end up not eating properly, you end up not sleeping enough, all the worry is making me anxious, sleepless nights. My glucose was all over, and that made me even lose my concentration, lose confidence. I almost became withdrawn until I had to go, I had to request for a... I was deferred because I couldn't continue going to uni. Then I wasn't working much.”

Audrey (f, 60+, Zimbabwe, asylum seeker) an asylum seeker who had been in the UK for 13 years and had previously been destitute but now lived in asylum seeker accommodation while her claim was being considered. She discussed how a change in her diet when in the UK, had, unbeknownst to her, contributed to her being diagnosed with type II diabetes.

“So the time I came here, you know, through friends, they say ‘Oh, you are losing [weight], you can have this chocolate’. I was eating chocolates. I think that’s where I get the diabetes. And I was starting putting sugar, little bit here, little bit until I was three teaspoons in a cup of tea. It was too much. I started to like the sweetness. I didn’t know the sweetness was going to kill me.”

Audrey ate food that was easily available and comforting in a time of uncertainty, unaware of the powerful effect it could have on her wellbeing. Particularly interesting here, is the way in which the food Audrey was eating was socially sanctioned. It was not just about what was affordable, or available, but what was comforting and fit in with social norms.

The second overarching narrative was the significant difference in ‘norms’ as regards keeping healthy in ASR participants’ countries of origin compared with UK, and the tension that existed for the ASR participants caught between those two norms at a time where there were several other significant pressures on them.

While healthy ‘behaviour’ had previously been considered a natural part of life, with food often perceived as automatically nutritious, and exercise being a fairly integrated part of individuals’ lifestyles in the UK, keeping healthy was considered to require active decision making, as well as the resources to follow through on those decisions. Though not described in these terms, there was a strong sense that Glasgow was an obesogenic environment. For many, exercise (aside perhaps from walking) was difficult to incorporate, and there were concerns about the type of food that were available and the preferences expressed by British consumers.

“People in this country, even in London, they love fast food, is it, like chicken and chips, fish and chips, whatever, whatever. And those fast cook in the microwave like noodles and some other pastas which you just put in there, and there’s rice which you can just put again. That’s the way they are.”

– (Mufaro f, 40-49, Zimbabwe, asylum seeker)

Given, the sudden move away from an environment in which ‘healthy’ choices were natural, or easy, Azzam (m, 40-49, Ghana, asylum seeker) who expressed a particularly strong commitment to healthy eating, raised concerns that Africans who were not used to thinking about what they ate, would adopt unhealthy lifestyles and suffer as a result.

“The worrying trend we see in this more and more people of black colour getting into this habit of you know, just eating the normal food around and not watching their diet because it has never been the culture of checking what you are eating in Africa.”

While Azzam's mention of 'people of black colour' could suggest a concern for a particular genetic susceptibility to harm, it also highlights the importance of cultural norms in shaping our food choices. His comment signifies an instance where individual, cultural and macro-level phenomena combine to impact negatively on health. If seeking out nutritious food is not considered particularly important to an individual because they were not previously in an environment in which it was common, or even necessary to do so, and if the most easily available food (due to cost, visibility of advertising, availability at food banks, new cultural norms etc.) is that which has deleterious consequences for health, it follows that individuals will consume foods in a manner that will put them at greater risk for poor health. As discussed above most participants expressed awareness about the positive and negative health effects of certain foods and so, the extent to which Azzam's concerns are justified is unclear. However, many did describe to me the changing perceptions they had of food since arriving in the UK suggesting that this is a process that might take some time.

To complicate matters, changes in the environment in which health behaviours were enacted, and changes in norms about health, occurred at a time when numerous external factors, in particular in relation to the asylum system, significantly reduced the autonomy of the participants to respond to those changes. These issues are explored in greater detail in the following chapters.

Chapter Six: Narratives of health and wellbeing

Chapters Six and Seven focus on the participants' narratives about health, wellbeing, and access to primary and preventive care. Although I draw on the theory of candidacy as a way to frame some of the narratives, the focus here is less on the theoretical implications but rather in exploring what these notions meant to the participants. Conversations with the ASR participants focused on two different (but related) topics. The first centred on perceptions: what does it mean to be healthy and well? How easy or difficult is it to stay healthy? To what extent did participants consider themselves at risk of NCDs²⁸? Could anything be done to prevent them? The second focused on engagement: did participants engage in preventive health practices? What was their experience of health service use? What does it mean to engage with preventive care?

In considering how one might start to develop preventive interventions, or engage people in preventive activities, an understanding of both of these areas is crucial. A preventive intervention will have limited relevance to someone if they do not consider that they are at risk of the outcome that the intervention is seeking to prevent. Thinking through the lens of the candidacy framework (recapped in figure 5), health perceptions, which are presented in this chapter, relate to the identification of candidacy, where individuals judge whether a service or intervention is relevant to them (Dixon-Woods 2005). An understanding of their experiences of engagement with health services and health practices, as presented in Chapter Seven, is similarly critical if one wants to consider how interventions and services might be developed in ways that cater to diverse sets of needs. Here, the significance of the next stages of the candidacy model are evident, from navigation, through to operating conditions.

This chapter starts with a presentation of the various ways in which the ASR participants conceptualised health. I subsequently explore some of the most significant practices that were considered to be important to the maintenance of good health – diet, exercise, and hygiene. The next part of the chapter describes ASR perspectives on prevention and preventive healthcare. Throughout, I also draw on the perspectives of primary care and public health professionals.

²⁸ Although I directed some conversation towards chronic disease (specifically diabetes and CVD) prevention, I was keen not to imply that this was necessarily the most important health issue for the participants and the conversations were therefore kept quite general.

It is important to note that some of the issues highlighted in this chapter, in particular perspectives on health and wellness practices, were talked about in significantly more detail by the female participants than the male participants who were generally in more isolated and precarious positions than the female participants and therefore more concerned with the immediacy of their situation. I explore in more detail the reasons that this may have been the case in the methodological reflections section of the discussion in Chapter Nine.

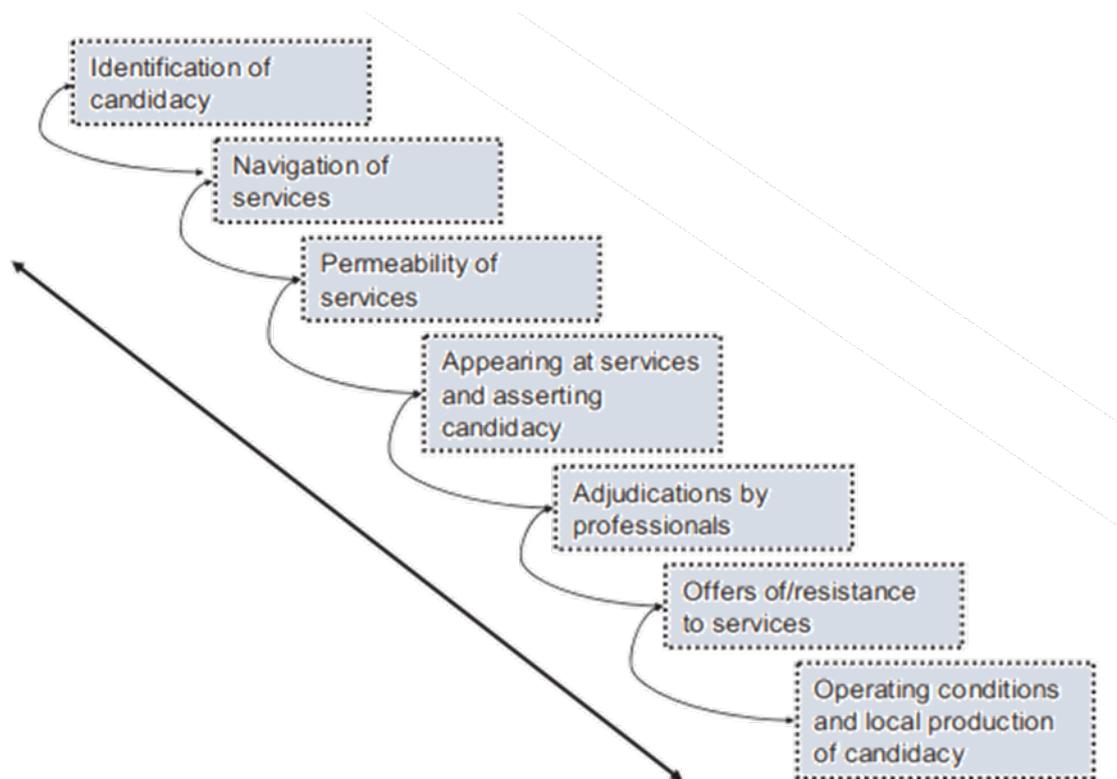


Figure 6: recap of the candidacy framework²⁹

6.1 What is health, and what keeps people healthy?

Starting at the micro-level with individual biology and moving outwards to environment and structure, I explore the various conceptualisations of health and wellbeing presented by the ASR participants and the ways in which the participants might feel ‘at-risk’ of certain illnesses. These perceptions all hold relevance in terms of the extent to which participants might identify themselves as candidates for particular services, interventions, or ‘practices’. While participants drew on a number of different tropes to describe what health meant, there was also a lot of fluidity in their descriptions, with health discussed in different ways at different times during the interview.

²⁹ detailed description provided in Chapter three

6.1.1 Biological basis of health and illness

“Sometimes it can be genetic, but as well... I think health is, well is something which we have to look for every time.”

- Hazel (f, 30-39, Zimbabwe, refugee)

Many of the ASR participants considered ‘genetics’ and ‘biology’ to be a factor in determining how healthy an individual was and how likely, or unlikely they were to get ill, albeit to varying degrees and with varying levels of uncertainty. Genetic factors had the potential to cause ill health, but were also able to act as a protective mechanism. Genetics (in lay terms) were discussed in two distinct ways: firstly, in terms of genetic susceptibility within individual families and secondly in terms of the ways in which being African might dispose someone to particular risks.

The more genetics were considered to impact on one’s likelihood of illness, the less important engagement with preventive health was considered to be. However, the perceived links between genetics and health were not necessarily considered in a linear fashion. Mufaro (f, 40-49, Zimbabwe asylum seeker), talked at length about the importance of a ‘healthy’ diet, suggesting that lifestyle might be a causal factor in explaining the presence of chronic diseases:

“Those elderly ones they are now not active, they are not doing much, they will just be spending most of their time sitting on the couch, smoking, eating, drinking, no exercises, maybe that’s why they are cumulating those type of diseases.”

She similarly attributed her own dislike of sugar to protecting her against the risk of diabetes.

“I said, ‘Ah, ah, me, I won’t be diabetic because I don’t eat too much sugar.’”

However, when she considered hypertension, she explained its cause in a very different way, stressing the extent to which it was an inherited condition. She felt herself not to be at risk, regardless of her diet, which included a lot of salt, because, to her knowledge, no one else in her family had suffered from high blood pressure.

“I said ‘I won’t have BP [hypertension]’ because in my family, my mum had BP before but now she doesn’t have it. Oh but she’s at age eighties and she doesn’t have BP. And so I won’t catch BP. BP’s a family type thing.”

Mufaro’s explanations underscore the importance of not assuming that because the links are made between one type of ‘behaviour’ and an illness this will necessarily be the case across all ‘lifestyle’ diseases. A lack of clarity on the relationship between lifestyle, genetics, and illness is not necessarily uncommon, and likely played out in conversations between many individuals. Indeed, Cooper et al noted that similarly mixed explanations were given by French- and Swahili-speaking Africans in Scotland, with genetics often suggested as a cause of illness when individuals could not think of another likely cause (2012:606).

Mixed messages about the genetic basis of chronic diseases point to two important roles for primary care and preventive health. The first is the necessity of exploring lay perceptions of disease causation and prevention as a starting point. Kleinman’s concept of explanatory models (1998), which seeks to elicit the patient’s own understanding and explanation of a condition or illness, is relevant here (with the caveat that lay models should not be used as a series of ‘tick-box’ traits (Kleinman and Benson 2006). Though Kleinman considered explanatory models in the context of clinical encounters, it is similarly important as a baseline for developing preventive interventions. If someone doesn’t consider there to be a causal link between ‘behaviour’ and an illness, then they will not identify themselves a ‘candidate’ for an intervention that aims to address that link. If someone doesn’t consider themselves a *candidate* for a preventive ‘behaviour’ or intervention, then that intervention will carry no relevance. Additionally, because an individual considers themselves to be a candidate for one health practice or intervention (e.g., limiting sugar in the diet in the case of Mufaro), it does not mean that they identify themselves as a candidate for all ‘healthy’ lifestyle practices. Individuals might, in fact, subscribe to multiple and conflicting candidacies.

Not unlike the ASR participants, there were mixed feelings amongst the professionals about the extent to which individuals might be at particular risk of chronic illness, and whether the basis for this might be related to genetics, lifestyle or a mixture of the two.

“And as well as the genetic predisposition as I understand it to developing things like coronary heart disease and diabetes and part of that is genetic as far as I’m aware and part of that is lifestyle.”

– Lucy, public health specialist

“I suppose the underlying stress is also a contributor to cardiovascular disease and so I know that there is an issue around that.”

– Kylie, public health specialist

The second way in which genetics was discussed related to the notion that Africans might be particularly susceptible to certain illnesses. Azzam (m, 40-49, Ghana, refugee) considered this to be due to the interaction between the specific biological makeup of Africans and the physical environment in which they found themselves in Scotland. As a result of this interaction, health practices that might not have been problematic previously might be responsible for causing illness here.

“The genetics of black people in the heat, you could take anything, especially with oil and stuff like that and but when you are used to it and you take, kind of practice the same culture here when you are not sweating and yet you are taking the sugar.”

Mufaro (f, 40-49, Zimbabwe asylum seeker) also drew on the notion that the makeup of Africans was different, suggesting that the poor weather in Scotland was more likely to affect them.

“Here I think maybe the weather it will affect the African born people to be here, they’ll be affected by the weather changes. And the bug is rather than me where we come from they are not much of bugs and the like.”

This raises important questions about the extent to which the ASR participants connected their skin colour, race, ethnicity, or nationality with their risk of developing certain illnesses. These concepts carry tangible meaning for individuals in a variety of different settings and, as suggested by this quotation, they are one of the elements that might contribute towards the identification of candidacy for particular conditions – an individual might draw on their colour or ethnicity in their understandings of their health, or in determining the extent to which they are at risk of an illness. This could be helpful in terms of raising awareness, or conversely unhelpful through increasing stigma. As discussed in the literature review, it is certainly the case that there are links between ethnicity and health outcomes (Nazroo 2003; Baradaran & Knill-Jones 2004), although the reasons for these links are complex and have both structural and genetic aspects that vary by ethnicity and illness type (Bhopal, Nazroo, Gill et al 2007). For example, evidence does suggest that individuals of South Asian origin have a higher than average genetic propensity to CVD and T2DM, as they are at greater risk at a lower BMI (Khunti & Semani 2004). Many

ethnic health disparities can also be attributed to factors such as socioeconomic disparities and racism however (Davey Smith 2000; Nazroo 2003), and it is critical to ensure that these differences are not naturalised.

Mixed feelings were expressed by the public health participants on the utility of researching health risks by ethnicity or migrant group. Adrian, an epidemiologist, felt strongly that research should be carried out in order to determine rates of illness amongst different population and ethnic groups.

“I think it's really important to understand why certain migrant groups may get the health outcomes that they get and I think it's sometimes interesting to compare different migrant groups and look at why there are particular differences.”

While there is arguable utility in this approach, it must be considered against the potential for certain groups to be stigmatised by being specifically targeted as ‘at-risk’ of certain illnesses.

“Do you think there’s kind of stigma there that it develops... there’s such a focus that even within the news and stuff that it gets, you know... there’s that association made with that community.”

– Janine, public health specialist

Qualitative research has shown for example that individuals of African origin are highly critical of HIV campaigns that are seen to target them specifically, even though individuals from Sub-Saharan Africa are considered a high-risk group for HIV in epidemiological terms (Smith 2016).

There are also broader risks related to defining ethnicity in health research, and using these definitions to explore relative illness risks, since any definition brings with it an element of homogenisation and reification of an imagined group (Bradby 2012). It does however impact on health in real and perceived ways, both at an identity level and at a structural level (Karlsen & Nazroo 2002; Waquar & Bradby 2008).

6.1.2 Role of ‘behaviour’

Continuing at the individual level, the influence of behaviour and lifestyle on health was discussed, in varying ways, in every interview and in each Ketso session, suggesting that

many participants subscribed to individualist paradigms of personal responsibility for health. In fact, ‘behaviour’ took up considerably more conversation than did biology, and ‘lifestyle’ was the first thing mentioned in all three Ketso sessions in response to the question, what does it mean to keep healthy?’

While views were mixed in terms of what lifestyle entailed, and the extent to which it was important, a degree of personal responsibility was considered important by every participant. Significant (and considered in depth in Chapter Eight) was the tension between an acceptance of the role of lifestyle for health and the level of control the participants felt they had in this regard. Discussions covered both the broad concept of ‘lifestyle’, with Glaswegian lifestyles often viewed critically as being responsible for poor health. Participants also focused more closely on certain specific behaviours most notably, diet, exercise and cleanliness, which are explored in Section 6.3. The participants’ emphasis on the behavioural determinants of health, and the location of blame for poor health at the individual level reflect Putland et al’s findings that lay perceptions of health inequalities tend to be explained at the individual rather than the structural level (Putland et al 2011:1). This is particularly striking since participants had not necessarily been raised in environments in which individual responsibility for health was a dominant narrative.

“Yes, yes there is [heart disease in Zimbabwe] although people don’t seem to really try and prevent it as such. You get to know that you’ve got a problem with your, you know, a heart problem, they don’t seem to, you know make an effort to keep it under control.”

– Tadiwa (f, 60+, Zimbabwe, asylum seeker)

However, narratives of personal responsibility had quickly been adopted and used as an explanatory factor for poor and good health.

“I say the lifestyle that people live if they are drug addicts, if they are into you know substance abuse then the lifestyle they lead.”

– Ketso 1 participant (responding to question on what affects health)

“I think I can live a healthy life if I really...see, I think it’s all about choices. How you, what you choose to make a healthy life.”

– Tadiwa (f, 50-59, Zimbabwe, asylum seeker)

Lawton et al 2007 compared accounts of type II diabetes causality of South Asian and white respondents in Lothian, Scotland. While the white respondents tended to blame themselves for their diabetes, the South Asian participants were more likely to call on external factors as an explanation, in particular drawing a link between diabetes and the experience of migration to the UK (Lawton et al 2007:899). Two explanations were drawn on to explain this. The first was the suggestion that the South Asians came from a holistic rather than an individualistic culture in which people are defined by the structures and systems they are part of, rather than than being autonomous individuals and so are more likely to view experiences in terms of those structures and systems (*ibid*: 902). The second, is that migration was such a defining feature in their lives that their experiences were likely to be considered against this context (*ibid*:903).

The ASR participants in this study sat in between these two poles. On the one hand they drew on narratives of individual responsibility to describe what made people healthy, demonstrating more in common with the white participants in Lawton's study. On the other hand, when they talked about themselves, structural explanations were used to explain why they were unable to keep healthy. Hodgetts & Chamberlain had a similar finding in their research on perceptions of illness causation amongst individuals of lower socioeconomic status in New Zealand. These participants also described health as an individual choice, but, unwilling to cast themselves as lacking in control, they detailed the structural factors that impacted on their agency (Hodgetts & Chamberlain 2000:334). One might have expected these individuals to respond in the same way as Lawton's white participants. That they didn't highlights the importance of taking care when attributing behaviour to assumed cultural and societal norms. As described in more detail in Chapter Eight, factors related to immigration status, poverty, and difficult living conditions were used by the ASRs to explain constraints on autonomy and engagement with health practices. Similar to Lawton's South Asian participants, the experience of the immigration process shaped explanations of their health practices.

“Yeah. I wouldn't say coming here has made things better for me. I can actually say it has made things worse for me, yeah, because tends to just eat junk like chocolate you know? But when I was back home I think they were not regular... they were available but I was quite careful about what I ate. But when it came here, sometimes you are so so you just, you know, like eat something. So stress is one of the things.”

– Tadiwa (f, 50-59, Zimbabwe, asylum seeker)

As described in Section 6.3, the most commonly talked about health behaviours were diet, exercise and cleanliness. Smoking and consumption of alcohol were rarely mentioned, except to criticise the behaviour of others (generally native Glaswegians). This may well have been simply because these behaviours were less commonly practiced amongst ASRs from Sub Saharan Africa.

“But to find someone with cigarettes, uh uh, it’s very rare. Just like beer drinking, very few women drink.”

– Brenda (f, 50-59, Malawi, asylum seeker).

6.1.3 The body as an indicator of health or illness

Discussions about the body demonstrated the gendered nature of notions of health and illness. Many female participants talked about their body size, and the way in which it was an indicator of their health. The body was variously described as a manifestation of cultural norms, outside of individual control, and an example of freedom and autonomy.

Differing cultural norms between countries in Sub-Saharan Africa and the UK were exemplified through perceptions of the body. Elizabeth (f, 40-49, Zimbabwe, asylum seeker) compared my body shape with hers to explain how married women in Zimbabwe were expected to have a large body - proof that they were being looked after by their husband.

“For my life I do compare most things from where I came from – because where I came from, they see a person like you, they’ll say if you are married, they are concerned when you are married. Say a person like you, your parents will say your husband is not keeping you well. They want to see a person who is married having a big body like me (...) I was size eight, size ten, and then I started, like, because every time I go home they used to say ‘your husband is not looking after you very well.’ And I started like, start eating eating – started like ‘oh I’m now a size twelve, fourteen’ When I came in this country I was size 16, but I finish having my children, I was very tiny. I do regret that body.”

My discussion about body sizes with Elizabeth demonstrated the extent to which the body carries symbols and meanings that extend beyond health (or lack of it) and the tension that can occur in the relocation to an environment where the body carries an entirely different set of symbols. Having been confronted with a new ‘norm’ in the UK she was now displeased with her body shape, attributing attitudes in Zimbabwe to a lack of knowledge about what is healthy.

“When I came here, that’s when I see, oh, that lifestyle it’s not good, we used to live on. It’s not good. If you see, like, most black women, we are big because of that – they believe a woman must be big, not small.”

Obesity is considered to be one of the most significant global public health issues (Campos et al 2006). Not only is it a risk factor for other diseases, but there are calls for it to be recognised as a disease in and of itself (Lancet Editorial 2017). Rhetoric around obesity is extremely fraught, however, and often draws excessively on notions of personal responsibility which shame those who do not conform to normative body standards (Campos et al 2006:56). Now in the UK, female participants had started to subscribe to western bodily norms and considered their previously ideal body type to be suboptimal.

Awo (f, 30-39, Ghana, asylum seeker), who was living with type II diabetes, discussed her body shape almost as something that was outside of herself and her control. She noted the change in her body since moving to the UK and was aware of the need for exercise as a means to manage it. However, while she felt that her diet and exercise levels were unchanged, her body had altered itself despite this.

“Me. Ghana. Dance the same. I did the same, like, dancing, everything, like yeah, it’s that’s right. But I’m a slim body, I’m not a big person. I’m small – even here, I’ve started coming bigger, yes.”

Bodies carry with them complex sets of meanings. Mercy (f, 30-39, South Africa, refugee) who had been a victim of domestic violence at the hands of her former partner before fleeing South Africa, described changes in her diet and weight in relation to this experience:

“Because when I came here in this country I was thin like you. Because of that situation of my husband beating me, stuff like that. So when I came here I feel much better now, it was no pressure, I was eating like stress free. Now I’ve gained weight. Now, now, after my status sorted, this way I feel relief.”

Mercy’s narrative exemplifies the complex interplay between a host of issues: diet, weight, wellbeing, body size, and gendered experience. While being overweight was not necessarily positive from a biomedical standpoint, for Mercy it was associated with security and ease. After the experience of domestic violence, and a gruelling asylum process, she was able to enjoy having an appetite. Although her physical health may be considered to be compromised, her mental wellbeing was significantly improved and she considered her body size from this perspective, as a physical demonstration of the ability to

live a life without fear or insecurity. Differing perceptions of weight may not just relate to cultural norms therefore, but also what aspects of our broader existence they reflect. Mercy's comparison of her weight with mine provided a reminder of the ways in which women are regularly required to judge their bodies against the 'norms' they see around them, and she was aware that her body size would not be considered the 'ideal' type.

6.1.4 Health as dependent on emotional wellbeing

Conversations on the meaning of health and illness were weighted towards discussions of physical health and chronic disease. However, the inextricable link between mental health and wellbeing coloured the majority of my interviews. Even when thinking purely about physical health, mental wellbeing is critical, since mental health issues can impact on individuals' identification of candidacy for other health issues, as well as the ways in which they engage with services (Kovandzic et al 2011: 769).

In the first Ketso session, when asked to consider what was important for health, a participant commented "*I'm thinking about mental health status of the person might have an impact on the physical health*". Participants continued to discuss the negative impacts of stress, anxiety, and depression, caused by (amongst other factors) fear and stress related to their race and status as asylum seekers together with social isolation.

The roots of chronic diseases were also considered to trace back to mental health, with high levels of stress noted as a contributing factor to potential poor health. Joseph (m, 40-49, Zimbabwe, refugee) and Nesta (f, 40-49, Zimbabwe, refugee), a married couple who lived in Glasgow with their two teenage children suggested that Zimbabwe's current economic situation might be leading to higher rates of chronic illness than previously recorded in Zimbabwe. They reflected on the fact that once diabetes and heart disease had been considered the preserve of wealthy individuals who could afford to eat western diets and live sedentary lives, but now concern about these illnesses, and particularly high blood pressure pervaded all sectors of society. In this narrative, stress was suggested to be both a direct cause of higher rates of chronic disease and also a mediating factor that led to an increase in unhealthy practices.

"You know, stress, people are stressed, you know, the economy is dead (...) so stressed people are always, you know, thinking or living for kids, where will I get the next meal, what will happen to my kids if I eat too much? You know there is so much, all the bills, where will I get money to pay those bills, so the stress levels, people are either going so it's just too much an even the food, like

we were saying, the cheap food is even expensive so people are no longer eating healthy, some go without a meal so I can imagine they are going for two days without eating anything, just drinking water the sugar levels in the body they drop and so it causes all sorts you know problems and...”

Melissa (f, 50-59. Zimbabwe, refugee), who herself lived with type II diabetes similarly attributed poor health and unhealthy practices to stress, indicating that it related to the numerous responsibilities that individuals shouldered, needing to care for large extended families. Her narrative exemplifies how several factors – political structures, family norms, poverty – layer on top of one another, to put individuals in positions of extreme vulnerability to poor health.

“There are people who are obese, yes, but as far as I know, taking it from my own experience, there is too much worrying because of extended families, too much responsibilities. You can be only one breadwinner in your family of 30 people, then they will all be looking for help from you. You worry over a lot of things, because when you are a breadwinner (...) So you will find mostly we have got a lot of problems. that is what triggers our high, our blood pressure – too much responsibilities over you and you just feel ‘I have to do it’. You feel obliged to do it. Although in some countries they don’t believe in extended family, it’s the nuclear family, but in Africa we’ve got that chain of pulling up each other. If your brother dies, you take over the children. If you don’t look after the children then no-one will look after them, not even the government will look after them.”

Research on migrant and ethnic minority perceptions of diabetes and CVD causality often highlights that many consider stress to be a significant risk factor (*e.g.*, Beune et al 2006). To the ASR participants this made intuitive sense, since even if there was not a direct causal link between stress and diabetes or CVD, being put under stress limited their agency to engage in practices that were beneficial to health. This will be discussed further in Chapter Eight.

Audrey’s (f, 60+, Zimbabwe, asylum seeker) experiences of asylum and destitution in the UK further underscore the ways that structural situations and mental and physical health intersect. Audrey spoke of the depression she experienced while as a destitute asylum seeker she was forced to sleep on the floors of various friends, fearful for what she might expect in the future.

“I was so depressed and then I got for depression tablets because of the living, the cost of living, it was very hard to me. I was a destitute for a long time, I think for three months. Three to four months, I was just two days I am sleeping

on another place. I said “I just want you for two days”, another one for one week, another one for... it was so stressing me.”

It was at this time, as a result of her depression and her precarious living situation that her diet changed to include more foods with a high sugar and fat content.

“Yeah, I was just eating. I was just eating, you know? It was the time I was just cooking and I liked the fat and the fat I needed and I just, so the time I was diagnosed diabetes, oh my heart, they were saying it’s full of, what do you call it? The fat is too much in me.”

The strong link between poor mental wellbeing, physical health, and the asylum process was evident throughout my interviews and addressed further in Chapter Eight.

The greatest specific health concern mentioned by the professional participants was that of mental health. While a considerable focus was on the previous trauma refugees and asylum seekers might have experienced, there was equally an awareness of the dangers of uncertainty and isolation to which many refugees are exposed once in Glasgow.

Ben, a primary care nurse spoke of the trauma experienced by many of his patients.

“Oh aye, there is lots and lots of trauma stuff (...) a lot of times it’s related to the specifics of where they’re coming from (...) and sometimes when people tell you stuff about how physically how they got here, a lot of time it’s seems unlikely, a lot of times it’s really horrific.”

He was further concerned that this trauma would be compounded by the isolation and loneliness that many refugees and asylum seekers experienced, particularly since the privatisation of asylum accommodation in Glasgow.

“big issue, especially for me as regards to mental health and with the wider sort of dispersal is people get so much more isolated now.”

Melanie, a GP was concerned that a focus on refugee mental health should not only address past trauma that refugees and asylum seekers might have experienced, but also the mental health effects of the situation in which they found themselves in Glasgow.

“But also practically is just this you know if people have got immediate health needs and they are actually in lots of social crisis and their mental health is really suffering because you know they have got no certainty over what their future holds.”

As well as noting the mental health risks of refugees and asylum seekers, there were concerns and uncertainty about the translation of mental health concepts into other cultures and the impact that this might have.

“Certainly things like mental health, they don’t necessarily translate and they don’t necessarily have a particular medical module for explanations for you know they don’t necessarily have the same views around health and about the causes of ill health on some occasions as perhaps we might have and I know certain things are not actually even translatable like the concept of mental health isn’t necessarily even translatable and and I think that there is a fair understanding that people that are fleeing or seeking you know asylum from these areas are likely to have experienced or often experienced quite a lot of kind of trauma.”

– Kylie, public health specialist

6.1.5 Health as influenced by the environment

“The visual picture that the environment paints is very important as well.”

-Azzam (m, 40-49, asylum seeker, Ghana)

The natural environment was also considered an important influence on physical and mental health and a particular point of contrast to what they had been used to. Although often discussed with humour, the weather in Glasgow was a regular feature of conversations, with the participants bemused by the constant cold and rain.

“The only different is the weather here, ah the weather, it’s horrible.”

– Melissa (f, 50-59. Zimbabwe, refugee)

“When it gets cold, it’s really hard to cope with cold weather.”

– Hazel (f, 30-39, Zimbabwe, refugee)

While humorous, concerns about the weather also had a more serious tone with a lack of vitamin D was suggested as a reason that Africans in Glasgow might be more likely to develop illnesses. Again the relationship between ethnicity and health was demonstrated through a concern that Africans may be more susceptible to vitamin D deficiency because of their skin colour. Although the evidence is inconclusive, some studies do suggest that individuals with darker skin synthesise less vitamin D (SACN 2016:140).

“I was told the weather is affecting my health (...) it’s a lack of vitamin D.”

– K003 participant

“Less vitamin D, the stress levels shoot up.”

– K003 participant

6.2 Perceptions of, and engagement with, health practices

6.2.1 Diet

Many of the participants, particularly (though not exclusively) the women, spoke at length about the role of food and diet in the context of what it means to be healthy. Consumption of certain types of food was discussed as a critical component in maintaining good health, with other types of food conversely potentially responsible for causing illness. The participants had varying views in terms of what constituted healthy food or a healthy diet, but many were clear that about the role of food in preventing or causing illness. Some of these views were influenced by mainstream dietary advice, but attachment to ‘traditional’ foods played an important role as well. Importantly, production methods were also considered to impact on the nutritional value of food.

The first substantive question I asked the participants was “what does it mean to be healthy”, or “what do you consider important to lead a healthy life?” For many, the first response related to healthy food.

“I think first and foremost good, healthy food should be available.”

– Priscilla (f, 30-39, Malawi, asylum seeker)

“First of all I say healthy eating. Yes. Because what you eat is what you get. So as long as you eat healthy, obviously you will be healthy.”

– Hazel (f, 30-39, Zimbabwe, refugee)

“What I consider important to me to live a healthy life, one will be my diet, the food that I eat, like food intake and stuff I drink, so I am an alcohol free person, never drank alcohol, never smoked, and I try to avoid too much calorie and meat and stuff, oil and stuff so I try to balance my diet in a way that is healthy.” – Azzam (m, 40-49, Ghana, asylum seeker)

These comments are indicative of the centrality of food in the ways that individuals think about health and wellbeing. If access to healthy food (however healthy food is defined) is considered in the same way as access to a health service or intervention would be, then this is a service that all participants identified themselves as a candidate for, at least in theory. Perhaps this is unsurprising, since it is something that is engaged with on a daily basis, but it does confirm the potential to use food as a basis for developing preventive interventions. As explained in Chapter Three, in the case of preventive interventions, it is often the service provider, rather than the individual who determines who is the target of an intervention. In the case of the consumption of healthy food, there is general consensus amongst both policy makers and public health specialists that this is a priority for all people, and participants had certainly bought into this message, even if it was not one they had heard before. The question of *who* is responsible for the the availability of food, mentioned by Priscilla, is perhaps less clear.

What constitutes a healthy diet?

Food is not simply fuel, but holds cultural and emotional value as well. Not only do these aspects influence what food ASR participants were willing to eat but they also influenced perceptions about what is considered to be a healthy diet. UK health advice was not unknown to ASR participants, many of whom emphasised the importance of eating a diet rich in fruits and vegetables and lower in sugar, salt, and fat. Participants talked of a “*balanced diet*” (Melissa, f, 50-59, Zimbabwe, refugee) and suggested foods that comprised this: “*for me, I like foods, apple, watermelon, and banana*” (Awo, f, 30-39, Ghana, asylum seeker). Though they did not necessarily draw causal links between dietary choices and specific health outcomes, the types of food to be avoided were those often considered to be unhealthy in public health and popular rhetoric.

“Not to eat too much fats, like using a lot of oil. Not to eat sweet things like chocolates and so on.”

– Audrey (f, 60+, Zimbabwe, asylum seeker)

“Too much fat, too much sugar, too much salt. Those three things, they are dangerous.”

–Esther (f, 60+, Zimbabwe, asylum seeker)

Many of the female participants expressed the importance they afforded to cooking themselves. While they might have been displeased with the quality of ingredients they were able to procure (both due to British production techniques and limited income), the process by which food was prepared was also considered to have an impact on health. Many were keen to discuss with me the cooking that they did for themselves. Although it is not unlikely that participants might have overemphasised the regularity with which they cooked, that cooking is of relevance is an important consideration for intervention development. To a certain degree cooking was a natural inclination (at least for the women) since they had been used to food that was obtained and prepared in raw form, rather than ready meals.

Anna: What sort of things do you cook?

Audrey: Mostly I cook vegetables. I cook. I do rice and some of the salads. I just buy some salad things, I do it by myself. If I need it I can have some potatoes, jacket potatoes and I do something with it which is not... doesn't have too much oil or fat. Some eggs, I just do balanced diet for my food, yeah.

The younger, male participants did not discuss cooking as much, though their views on the nutritional properties of foods were similar.

Cooking was, however, often easier said than done. Birhan (m, 20-29, Eritrea, refugee) noted some of the reasons he did not cook for himself, despite feeling that it was the most sensible thing to do. There is likely a gendered element to this, with Birhan a young single man, unaccustomed to the process of cooking.

“You don't know what you are eating, you are so tired, you come in from work, you don't want to do you know so the easiest way is to go the supermarkets and buy something and put it in the microwave and eat (...) you need to cook, so like a young person like me, I'm not familiar with cooking so that is the easiest for me was to go to shopping centre, buy something and you know, something easy to cook.”

When ASR participants began to speak about which foods they were used to at home, the psychological and emotional importance of food became increasingly clear. Whether food was considered healthy was not solely related to its nutritional value. A number of conversations centred around the value of 'traditional' and familiar foods, which were considered to be both nutritious and satisfying.

“I always used to have more carbohydrates than anything back in Africa and I still do that here. It might be different types but still do that, so maybe it hasn’t changed a lot.”

-Priscilla (f, 30-39, Malawi, asylum seeker)

The participants from Zimbabwe talked extensively about sadza, a corn based foodstuff, easily obtainable in Glasgow, which they ate regularly:

“My country. We eat what we call Sadza. Sadza is cooked with mealie-meal, maize meal. You make it like porridge, then when it bubbles, bubbles, bubbles, bubbles, like what porridge does, it bubbles for some time, you don’t just – if it bubbles a little then put – but it bubbles for some times then you add mealie-meal to make it a little bit thick and then you add some relish. Like meat, like vegetables. That’s the only different things that you can eat with sadza, so if I eat the sadza it’s something – I become, I – my stomach it comes satisfied.”

- Esther (f, 60+, Zimbabwe, asylum seeker)

Not only was sadza, along with other ‘traditional’ food, considered to be healthy, but it was also considered to be the only effective means of satisfaction.

“I am used to my traditional food, so if I – I can eat other foods, but I don’t get satisfied. But I eat that, my traditional one, like, it’s just fine. If I eat other foods, I get hungry quickly. Hmm. But if I eat my traditional because I am used to that, I stay for a longer time without being hungry.”

-Esther (f, 60+, Zimbabwe, asylum seeker)

“Ever since we have been cooking Zimbabwean food. Yeah, our staple food, that's the one. I think it's maybe psychological – if you eat that way, we feel full? And you feel I've enjoyed my meal. We can eat the Western type of food here and there but basically we just have to eat our... at least almost every day. Yeah, we cook it. Cook the maize meal, vegetables on their own, then the meat on their own. It’s, either have beef, sometimes chicken. We get (?) chicken from the Asian shops. Then sometimes fish. Yeah, it’s always fish some fish, vegetables and our staple meal which is mainly carbohydrate. Yeah.”

-Melissa (f, 60+, Zimbabwe, refugee)

Although the participants considered food to be intrinsic to health, these comments demonstrate its wider symbolic and cultural significance as well. Food that would not necessarily be considered an ideal staple from a biomedical perspective given its high starch content, was considered to be the most satiating and therefore of high value. Additionally, the emotional attachment that familiar food elicited was clear, not just

through the rich and detailed description of how it was prepared (as with Esther's description above), but also in the words the participants used to describe it – for example 'satisfying' and 'psychological'. Indeed, when contemplating her constant tiredness, Mufaro, an asylum seeker from Zimbabwe, suggested the different type of food her as one potential cause

“It's like all the time I will be tired (...) in Zimbabwe I don't feel, I wasn't feeling the same, maybe because of the food.”

The cultural and symbolic value of food has long been discussed by anthropologists, starting in particular with Levi-Strauss in the 1960s and 1970s who posited that food preferences are 'culturally shaped' and reflective of social structures (Caplan 1997:1). This has fed into interventions that seek to be culturally competent. Reniscow distinguishes between two levels of culture – deep and surface level – both of which need to be addressed in an effective culturally-adapted intervention (Reniscow 1999 *in* Liu et al 2016). Food is considered to be a surface level element, one that, if incorporated appropriately, will increase the appeal of a health intervention (e.g., including recipes for more nutritious versions of traditional foods) (e.g., Brown et al 2007). The ways in which the ASR participants talked about traditional foods suggest that food might have a deeper level of resonance as well, and while this should not be overstated – there are numerous reasons other than cultural that people eat the food they eat – interventions to increase consumption of, or access to, nutritious food must take this into account.

Concerns around food production

“You know in the media they talk a lot about healthy eating you know, the five a day, but when we are back in Zimbabwe, you have got natural, organic, it's just natural foods that are maybe something which just forces you to live a healthy life.”

– Tadiwa (f, 50-59, Zimbabwe asylum seeker)

Attachment to familiar food extended beyond types of food, to a sense that food produced in the UK was intrinsically less nutritious than the food produced in their countries of origin. This was attributed to the fact that food in Africa tended to be organic and consumed soon after harvesting. The consequence of this is that whereas it had been reasonably straightforward to maintain a healthy diet previously, this was considerably more difficult in an environment where the nutritional value of food could not be taken for granted.

“You know in South Africa like, I think our food is different. You know, in the home people, they eat that organic food, like farm food (...) you plant your cabbage, carrots, green beans.”

-Mercy (f, 40-49, South Africa, refugee)

Food in the UK was not considered to be fresh or natural and the participants discussed rumours that UK produce had been chemically altered. Cooper et al noted similar concerns amongst French- and Swahili- speaking Africans in Glasgow who were concerned about levels of chemicals in the food they ate in the UK and attributed seemingly higher rates of cancer in the UK to this (2012:607).

“The food that we call fresh here you can’t really tell if they are really fresh compare to the natural fresh food.”

-Azzam (m, 40-49, Ghana, Asylum seeker)

“Yes, I’m just reaching but to me I’m not happy because of the food, I’ve seen the chicken being given they say they were too tiny and they will be putting some more and they will be big chicken they will sell them for people is that right?”

Participant in Ketso 1

“There is so much chemical in the food you eat, you eat here now because chicken it has to have some chemicals for it to grow, because like in my country, a six week old chicken you can’t eat, we say it’s not ripe enough to be eaten, whereas here you, they have given food, by six weeks they are ready to be eaten you see so they grow because of chemicals so when you eat those chemicals will affect you also so it’s the chemicals I think that affect people that are in the food, that’s the way I think.”

– Brenda (f, 50-59, Malawi, asylum seeker)

These concerns further emphasise the link between food and psychological wellbeing. That which was familiar and reminded them of home was healthy, and a source of ‘wellbeing’. That which was from the UK, was unfamiliar and potentially suspect.

The gap between identifying and obtaining nutritious food

While all participants identified themselves as candidates for the consumption of nutritious food, the issue became less straightforward in terms of availability and access. In answering the question of what it meant to be healthy, Priscilla’s first comment was that

“*good, healthy food should be available*”. Important here, is not simply that she mentioned food as integral to health, but that she focused first of all on its availability. It is not simply enough to know that good food is important, but individuals must have the ability or opportunity to obtain it as well. Considering the candidacy framework (Dixon-Woods et al 2005), the themes of ‘navigation’ and ‘permeability’ are crucial here. Having ‘identified’ themselves as requiring nutritious food in order to keep healthy, the question moves to how easy it is to do this, and what barriers might be in place in terms of navigating this landscape? To what extent was nutritious food easy to find, buy and prepare?

Many of the ASR participants spoke of the choice they had to consume foods that would be beneficial for their health. In doing so, they ascribed to narratives promoting individual responsibility for health, the paradigm through which health behaviours have traditionally been understood in public health (Bambra et al 2005; Brassolotto et al 2013:322).

“The way you buy your food is what matters because if I choose to buy bread and then maybe cokes, that’s my choice.”

– Brenda (f, 50-59, Malawi, asylum seeker)

Although personal responsibility was advocated for in principle, there were many barriers that stood in the way of ASRs being able to consume nutritious food in the way that they considered ideal. Nutritious food was considered both difficult to find, and, due to cost, difficult to purchase. Difficulty finding good food related partly to the notion that food produced in the UK was simply less nutritious than that produced in Africa (as described above). In addition to production techniques Mufaro (f, 40-49, Zimbabwe, asylum seeker), described the food environment as obesogenic (though not using that term), highlighting the ubiquity of unhealthy food and the tendency of people in the UK to choose that over home cooked meals: “*People in this country, even in London, they love fast food, is it, like chicken and chips, fish and chips, whatever*”. Lack of availability of nutritious food was not the only factor. Birhan (m, 27, Eritrea, refugee) who had been in the UK for nine years, noted the disjunction between awareness of the need to eat healthy food and do exercise, and knowing how to do it in practice.

"No it's very hard because well a lot of people say, these days it's much complicated because whatever you eat food it's always related to, it's bad whether it's related to all this cancer and this but everything is bad these days and you say I am going to better, is it exercise going to make me healthy? I'm not quite sure because you can exercise but exercise is not because the running

machine or you know lift the weights that wouldn't improve your health because even though you go to the gym they will ask they tell you it's always what you eat."

Birhan's comment encapsulates the complexity of the information we receive about the role of diet on health. From the perspective of a consumer it can often seem that on an almost weekly basis, a new food group is promoted as either the key to good health, or the cause of poor health. This can be confusing even for individuals who have grown up with 'healthy eating' narratives, let alone those who come from a region where food was not considered in this manner. The candidacy framework uses the term 'navigation' to describe the ease of finding the appropriate service or intervention. Here navigation is complicated by mixed messaging about what is healthy and what is not.

By far the most significant barrier to healthy eating, however, was financial. The participants' finances limited them in this regard for two reasons. Firstly, because nutritious food was deemed to be more expensive - as Brenda (f, 50-59, Malawi, asylum seeker) noted '*if you have money, you eat healthy*' and secondly because many of the participants often had insufficient funds to buy food at all and therefore had to resort to food banks where they had no choice as to what food they could have. In this setting the disjunction between the participants emphasising the value of making nutritious food choices and their capacity to do this was particularly stark. The message appeared clearly: healthy food exists; if you have resources you can make the choice to consume it. Chapter Eight which focuses on the structural determinants of ASR health and healthcare looks at this dichotomy in significantly more detail.

"People want to eat healthy, but there are days when you don't have anything, you don't have money, so the better option is to buy it, the £1 pizza."

– Joseph (m, 40-49, Zimbabwe, refugee)

"Yeah when I moved here, yes. That's when I realised you can eat whatever you want as long as you can afford."

– Melissa (f, 50-59, Zimbabwe, refugee)

A final barrier (again explored in detail in Chapter Eight) did not so much inhibit ASRs' capacity to navigate or access the food environment so much as limit the extent to which they felt eating healthily was relevant. The asylum seeker participants in particular, had huge pressures and anxieties placed upon them, and in this context, obtaining and eating

nutritious food was not a priority. Indeed, many participants discussed significant changes in their diet, and subsequently their health, in the context of their migration to the UK and subsequent engagement with the asylum system.

People have stopped cooking; they just eat anything. They boil noodles. How is it going to be healthy eating noodles? And they will just go into Tesco and the vouchers you get, you can get Coca Cola which I don't think is healthy myself and it's just... it's tinned soup which they didn't even make themselves."

-Thandi (f, 30-39, Zambia, asylum seeker)

6.2.2 Exercise

"Being active. If you can't go to the gym, you can walk, all those things."

– Melissa (f, 50-59, Zimbabwe, refugee)

In much the same way as food, and in line with the emphasis on behaviour as a cause of good or poor health, ASR participants suggested that exercise could have a positive impact on health and identified themselves as candidates for this practice. While nearly all discussed its importance, there was considerable variation with regards to the extent to which exercise was engaged with. Notable was the fact that those with refugee status were considerably more likely to engage in regular exercise than those who were waiting on asylum claims. Those with refugee status were also more likely to consider exercise in broad terms and talk about a wide range of activities.

Many participants noted that exercise as an active choice was a new concept for them since living in the UK. Previously exercise had been a part of daily life (particularly for those participants who came from rural areas) rather than an activity that needed to be actively factored in.

"It's just a job, but we didn't know that it helps to lose weight, because, like, you wake up early in the morning, you have to sweep the outside yard."

– Elizabeth (f, 40-49, Zimbabwe, asylum seeker)

"Most of them they don't go for the gyms and the like because the way they will be doing their stuff, that's the more exercise."

- Mufaro (f, 40-49, Zimbabwe, asylum seeker)

Where exercise had been relatively easy (if unintentional), it now took concerted effort to integrate it into a lifestyle that did not lend itself to being active, at a time where many other constraints were placed on people's lives.

“Here when you first come and it was a bit harder, but in Zimbabwe I think it's easier to keep fit because you are walking, you walk here and there.”

- Joseph (m, 40-49, Zimbabwe, refugee)

6.2.2.1 Access to exercise

It is not necessarily lack of knowledge that prevents individuals from migrant and ethnic minority backgrounds from engaging in 'healthy' practices, but other barriers that get in the way of putting that knowledge to action. Kampf and Göksu's research on CVD prevention amongst Turkish migrants in Germany suggested that knowledge on health practices existed but was not reflected in behaviour (2014:22). When talking about exercise with the ASR participants, a disjunction occurred between the ways individuals talked about exercise, the extent to which they felt it relevant, and their perceived capacity to carry it out. This related in part to the notion that while exercise might be advisable for individuals in theory, it was not something that was necessarily relevant to the ASR participants in their current situations. Essentially, the 'operating conditions' in which they existed in Glasgow had an impact on the extent to which they were able to navigate and access opportunities for exercise.

Barriers to exercise

Barriers to engagement with exercise existed at the meso- and macro-level. These 'operating conditions' in which engagement with exercise took place affected many aspects of the candidacy journey. The majority of participants did not have exercise integrated into their lives in practice, perhaps aside from walking. Explanations for this ranged from the prosaic – stressful working lives – to the strictures placed upon them by an uncertain asylum status. Joseph's (m, 40-49, Zimbabwe, refugee) comments, for example, might have been made by anyone who worked in a full time, sedentary job, as he did:

“But when you are in the car is just so it's walking to the car to work and the office is almost some distance and you are seated all day, you don't have the time when you get home, you are tired, you just sit and so the chances of you know, going to the gym and not doing anything.”

For the asylum seeking participants, and those refugees who did not have full time employment, the financial barrier to exercise loomed the most prominent. It is interesting that for many participants the exercise that was considered most legitimate – going to the gym – was the one form of exercise that was out of bounds due to cost. For Tadiwa (f, 50-59, Zimbabwe, asylum seeker), the cost barrier was enough to remove the notion of exercise from the table entirely. *“Exercise is also important but we just don’t have the availability of funds to get involved in that. While exercise might have been appropriate in an ideal situation, it was something that was off limits for her as an asylum seeker.*

As Thandi (f, 30-39, Zambia, asylum seeker) noted, spending money on exercise would mean choosing that over a more concrete need. This was not to say that there was a lack of interest, but rather that it was beyond individuals’ means.

“Quite a number of them would want to do that but if they have to pay to do it, so it’s a money issue. So if it was free maybe they’ll try and make time. Quite a number of them would try and make time but...so instead of going to pay for the gym they want to use that money at least to buy something for their house.”

Concerns around financial barriers to exercise had not eluded the professional participants. Mary Anne, a public health specialist, was well aware that financial considerations extended beyond simply being able to afford entry to an activity, but also to the ‘kit’ that might be required to engage in that activity (e.g., a swimsuit), or even the transport to get to the activity in the first place:

“Access to free physical activity or reduced cost, that has been a huge issue but not only just access, even being able to get the equipment.”

Efforts to engage individuals in exercise therefore require consideration of financial barriers in their broadest sense.

One operating condition – specific to the female participants – was the perceived safety of the local community. Hazel (f, 30-39, Zimbabwe, refugee) had recently finished an engineering degree and lived in Glasgow with her two daughters. She spoke a lot about the importance of exercise, considered the plethora of walking and cycle paths near where she lived to be a positive facet of the neighbourhood and was pleased that opportunities for free exercise existed: *“with the gyms you need to pay and things like that. But still, as I say, you know, they are providing us with place where you can just walk, or cycle, or what”*. However, as a woman she did not feel that she could access these without fear.

“These footpaths that are along the loch... Sometimes I find it a bit scary to just walk on your own, you know, with lots of things happening everywhere (...) even if I want to exercise on my own, I still can’t do it. Because when I think, ah, when I go down that place, there’s trees everywhere, and how about if someone attacks me, you know.”

Hazel had clearly recognised that exercise was important and identified what opportunities might exist to do it, but her status as a woman meant that she felt that those opportunities were off limits. To refer back to the candidacy framework, concerns over safety reduced the permeability of exercise opportunities.

Others were inhibited, not because of being isolated, but due to a fear that they might bring undue attention to themselves by being visible in their local area. When I asked Asmeret, an Eritrean asylum seeker whether she liked to do exercise, her response indicated her concern that she might create a disturbance:

“Yeah I walk, well a little bit walking I like to walk and because for to make exercise in the house is not like, if you go out is maybe difficult, I’m scared to disturb people. And still now not doing any exercise. Just some walking for a little bit, then come back. That’s all.”

Elizabeth (f, 40-49, Zimbabwe, asylum seeker) expressed similar concerns noting that although there was a park nearby to where she lived, she did not feel sufficiently comfortable in her neighbourhood that she wanted to spend any longer outside than was strictly necessary. As a result, she felt that her ability to engage in even basic activities that might keep her healthy was significantly restricted.

“I don’t think there’s anything which I can do here which can keep me healthy – because walk you know. We used to walk, and here, I’m even afraid to go there by myself. But home, we used to walk.”

This influence of the wider context, or operating conditions, on the ASR participants is explored in further detail Chapter Eight.

6.2.2.2 What facilitates exercise?

While several barriers to exercise existed, a number of participants had integrated exercise into their lives on a regular basis, with the intention of enhancing their health and wellbeing. Although of course, personalities differ and across any population some will find this easier than others, it is useful to consider what characteristics these participants

shared. Community groups and children's activities played a role in helping people normalise and integrate exercise into their lives. The other significant characteristic was that all those who had made exercise a part of their lives in a meaningful way had settled refugee status. This afforded them a sense of stability and security that the asylum seeker participants did not have. Joseph and Nesta, for example who both had settled status and full time jobs were keen to tell me that they had "*just come from the gym actually*" prior to our interview. Similarly, Melissa who also had refugee status took me past the gym as we walked around her neighbourhood. Exploring the differences between those who participated in exercise and those who did not provides important insight into the ways that individual preferences are mediated through a number of different levels, from the sociocultural to the structural.

Netto et al suggest that one important facilitator of culturally targeted interventions is to 'use community resources to publicise the intervention and increase accessibility' (2010:248). Because exercise can be done in a group, it provides an opportunity for community and public health organisations to engage individuals in activities that are positive for physical health, but also promote social cohesion and enhance mental health. This involvement at a community level was apparent in the interviews.

Thandi (f, 30-39, Zambia, asylum seeker) was actively engaged in helping organise ASR community groups. She noted the role that community organisations can play in helping individuals to integrate exercise into their lives whilst also strengthening social bonds. She suggested that because exercise was not something that people naturally thought to do, it had to be integrated in a way that resonated with other parts of their lives. Although individuals might identify as candidates for exercise in principle, they were unlikely to seek out opportunities that would make this a reality in practice due to the broader conditions in which they live. The linear nature of the candidacy model is called into question here, since as Thandi suggests, the most important aspects following identification in this regard are not navigation, permeability or adjudication, but the ways that exercise opportunities are presented and offered. Exercise offered through community organisations had greater salience and also served to reinforce community ties.

"Here, it's a few African women I've seen going to the gym, but otherwise no they don't. It's... That's still I think this is why, like, community groups try to do programmes like Zumba where women can come (...) and this is encouraging women to still come out and do a bit of exercises. So there's more Zumba now in community groups where women are being advised to do like exercises. But otherwise they're so laid back when it comes to exercises."

- Thandi (f, 30-39, Zambia, asylum seeker)

Awo (f, 40-49, Ghana, refugee) offered an excellent example of this. She had started doing Zumba through a community group and it had become integrated as an important part of her life. Dancing had cultural resonance, as she used to dance a lot in Ghana, offered her community ties, a level of physical fitness and a sense of wellbeing.

“Me, I like exercise. If – when I was telling you this now, maybe this is a exercise too, certainly I can just work out now. I like dancing, and dancing like I can’t stop now, can’t stop dancing. Because of that I do direct Zumba. Zumba classes for fitness. I used to do it in X community centre every Saturdays, yeah.”

“[Dancing] make me feel better. As soon as I start, I can be dancing from right now ‘til next morning.”

For some of the men I interviewed, many of whom were particularly isolated, engagement in group sports was one of the few opportunities they had to forge any kind of community connection. Perhaps its most relevant role in this case was as a provider of emotional wellbeing. Hagos (m, 20-29, Eritrea, asylum seeker), who had spent most of his life in a refugee camp in the Sudan lived a particularly isolated life in Glasgow. He had however, been able to play sports and meet other Glaswegians at a community group.

“Yeah, I once participated in some sports activity.”

When exercise became normalised through the activities of peers, community groups, or even children, participants were more likely to engage in it. Mercy (f, 40-49, South Africa, refugee) spoke of how, in taking her young son to the swimming pool, she had come to see it as an exercise she could take part in as well.

“I used to be scared of swimming, now when I take my son I will go swimming as well (...) I’ve overcome the fear of swimming now. I can go. I can’t run because of my chest, I can’t do exercise but I need to take care of my eating and I go for swimming pool. I don’t have problem with the swimming pool.”

Thandi described a similar situation where children’s engagement in everyday activities had a knock-on effect on the mothers also. The more exercise was normalised as an everyday part of life, the more individuals identified it as a relevant to them.

“Maybe the mothers have ended up joining the gyms because they have to drop their children somewhere else and while they’re waiting for their children

maybe they're in the swimming pool or doing something else, so it's like the children have also empowered their mothers to do something."

6.2.3 Cleanliness

The final health practice that was discussed in detail was that of cleanliness. These conversations were particularly gendered, with the female participants, exclusively, discussing the importance of keeping food, homes and bodies clean, and describing the presence of dirt as a source of fear.

Awo (f, 40-49, Ghana, refugee) lived in a high rise with her young son, and had another son remaining in Ghana. She spoke with particular concern about the fear that germs from the outside might cause harm to her health, and detailed her strategies for avoiding this. This reflected the idea that threats to health were external and ubiquitous, and constant vigilance was necessary.

"At least keep your environment, your place tidy, neats, you know. You come back, you make sure you wash your hand, is germs out there. You don't know if you're touching me, If I touching a –door opened, I'm not, my mind is at – I will take this wipe and wipe the door every time. I am so curious about that. I am very, very aware. You won't see the germ but it is there, even in bus, holding all these – oh, as soon as I get home I will take tissues in my bag, clean my hand. Is very important."

Asmeret (f, 30-39, Eritrea, asylum seeker), and Audrey (f, 60+, Zimbabwe, asylum seeker), spoke of the health threat posed by food that had been obtained externally. Asmeret discussed the strategy she had developed to mitigate this risk, using lemon as a type of disinfectant:

"If I buy I also put lemon, you know the lemon? I put lemon and I eat. I don't, I scared."

Audrey similarly discussed concerns around dirty food, suggesting that it was dirt that made food from certain types of establishment unhealthy.

"The way they do their pizzas, ugh. And the place is... it was not clean, to me anyway, the dishes, the towels they use."

As well as focusing on risks in the external environment Asmeret (f, 30-39, Eritrea, asylum seeker) and Esther (f, 60+, Zimbabwe, asylum seeker) both spoke of the importance of

keeping their own bodies and surroundings clean. For them risk was produced internally, and required a level of self care to manage.

“To be healthy I clean my house and I wash my clothes, keep cleaning myself, yeah.”

– Asmeret

“Personally I should be, you know, clean. I need to be – I attend to myself, wash my body, brush my teeth, I should put on nice clothes.”

– Esther

There are a number of potential explanations for these perspectives on cleanliness. It is relevant that in Sub Saharan Africa, despite increasing rates of NCDs, there is significantly greater attention paid to infectious disease models, which are still the largest killer (Global Burden of Disease Risk Factors Collaborators 2015). In that context, it makes sense that participants would draw on models of infectious disease transmission (e.g., germs) to describe what causes illness. Cooper et al 2013 similarly noted that participants used the language of infectious disease transmission, even when talking about chronic diseases (Cooper et al 2013:603). Secondly, cleanliness was something that the ASR participants were easily able to maintain control over. Unlike exercise and eating health practices, cleanliness was not an area that required the involvement of any other party. Thus, candidacy did not need to be sought or negotiated. In a setting where many aspects of their lives were out of their control, participants were able to present themselves as clean and tidy, and therefore looking after their health.

6.3 Perceptions of NCD risk, primary prevention and preventive care

6.3.1 Perceptions of NCD risk

Considering NCD prevention relevant requires first considering that you as an individual are at risk of NCDs, and secondly that this risk is modifiable. Aside from those who were already living with diabetes, and despite general consensus on the importance of keeping healthy, few participants had considered that they might be at risk of either diabetes or CVD themselves

Anna: Who might be at risk of getting illnesses like diabetes or heart disease?

Elizabeth (f, 40-49, Zimbabwe, asylum seeker): I don't even know the causes of that, so I'm not sure to be honest.

"I don't really know what how they kind of, what they do, thankfully I don't have any habits. I've heard about people who have got diabetes but I don't really know what they get."

– Tadesse (M, 40-49, Eritrea, asylum seeker)

Nicholas, a public health professional who worked specifically with individuals from Sub-Saharan Africa agreed that awareness of chronic diseases amongst this population was very low, and that individuals from Sub Saharan Africa might not consider themselves at risk.

"You might have it just shows up noticing things, you might have issues but I think to my understanding like disease like diabetes or cancer they are not really a big issue for them but it might be, it's good, and I'm sure there is no, there is very little awareness about this kind of disease among migrant communities."

Along with a general sense that life was healthier in Sub Saharan Africa, many participants suggested that chronic diseases, such as diabetes and CVD, were quite uncommon.

However, while many participants expressed the view that diabetes and CVD were not common in their countries of origin, some questioned whether this was in fact the reality.

Thandie, an asylum seeker from Zambia, who was engaged in a number of health promotion activities in Glasgow reflected on this:

"Oh I would say people must have had it. I know people who have had it, but I think it wasn't just even monitored, it wasn't picked up, and quite a lot of people never even went for testing."

Although there is now significant public health concern about the burden of chronic diseases in developing countries, including Sub Saharan Africa (who.int), this is a relatively new consideration with most focus to date, being placed on infectious or communicable disease. This, in part, might explain why many of my participants had a sense that chronic illnesses such as diabetes and CVD were not present, or at least common in Africa, while awareness of HIV (which I did not bring up in the interview) was much more common, with more than one participant talking about the HIV prevention initiatives they had been involved in, or mentioning their own family history of HIV. Brenda (f, 50-59, asylum seeker, Malawi), for example, had been involved in HIV education in Malawi.

“There was a group that was formed, those who wanted to be tested [for HIV]. We approached the hospital so that people could be tested and then they started living with it, so the moment people knew those [people] were HIV positive, the families didn’t want to have any association with them so that when they fell ill nobody cared for them, nobody would come near them to give them food so such people I used to go and give, to help them have their medicines.”

During extended conversations about meanings of health and illness, I broached the concept of preventive health and the extent to which the participants felt it to be relevant to them. While prevention was considered by most to be personally relevant, it was also acknowledged this was a relatively new concept. For most, health had previously been a focus for consideration only when something was wrong. Since moving to the UK, ideas around preventing illness before it struck had started to seep into the participants’ consciousness.

“Even growing up I think after my secondary school, I never even heard my friend who said ‘oh, I’m going to the health centre to get checked for this and get checked for that.’ That’s a language I never heard. I would be lying if I said I did. But all these things have become more known to me living here, do you know? It’s like you pick a leaflet, you’ve read about it and you say ‘oh right. I think I should do this.’ You’ve seen this but all this information being passed around, this information I think we lacked back then and I’m hoping maybe it’s there now.”

- Thandi (f, 30-39, Zambia, asylum seeker)

In the same way that the concept of prevention, which involves considering your health while you are still healthy, was new, the idea of seeking out healthcare while healthy, rather than only in an emergency, required an adaptation from previous norms.

“You can imagine, someone like that [someone living in Africa] they won’t be bothered by going for a check up when they are fit and healthy so that increases the risk of diseases.”

– Nesta (f, 40-49, Zimbabwe, refugee)

“All these things have become more and more known to me living here, do you know? It’s like you pick a leaflet, you’ve read about and it you so oh right, I think I should do this.”

Thandi (f, 30-39, Zambia, asylum seeker)

While the awareness that there were things you could do to prevent illness was largely considered positive, Nesta (f, 40-49, Zimbabwe, refugee) also pointed out the fact that

identifying yourself as an individual actively ‘at-risk’ also carried the side effect of increasing anxiety. Even if one engages in preventive practices there is a chance that they will not work, or it will be too late.

“Yeah I think it’s a big change because you can imagine if you are not aware of you know, diseases that can attack maybe people from 50 so you don’t worry about such things but once you are aware then you start thinking because some of these diseases that you can get maybe when you are 50, if you start eating healthily from now when you get to that point you might you know, suffer them even later than life than you know that age so you start worrying about what you eat, exercise and doing all these things...”

Despite this, prevention was still a concept that had salience with many participants, at least at a theoretical level. Participants made comments such as ‘*Prevention is better than the cure*’ (Audrey, f, 60+, Zimbabwe, asylum seeker), ‘*yes why not, it’s very important to our life*’ (Awo, f, 40-49, Ghana, asylum seeker).

Not everyone considered prevention relevant to them however. This was due to a lack of awareness, an emphasis on the genetic element of diseases that they could not control, and the fact that prevention was a low priority. This was expressed quite clearly by Mufaro (f, 40-49, Zimbabwe asylum seeker):

“I don’t think there’s anything which I can do to keep me healthy.”

A difference occurred between generalised discussions about what might prevent people from getting ill and specific discussions about what might prevent people from developing cardiovascular disease or type II diabetes. Participants were comfortable talking about preventing illness in a broad sense, but were less clear about the specific risk factors that might relate to NCDs. When talking about preventing illness in general attention to diet and exercise were considered to be two key features for prevention.

“I’ve always been careful about that because I do eat chocolate and biscuits but when it comes to sugar intake I really limit myself.”

– Tadiwa (f, 50-59, Zimbabwe, asylum seeker)

“For those elderly ones, they are now not active (...) maybe that’s why they are cumulating those types of diseases.”

- Mufaro (f, 40-49, Zimbabwe, asylum seeker)

When the conversation turned to consider diabetes and heart disease specifically, the participants were unsure how exactly health practices might affect their chances of becoming ill, even amongst those who were living with diabetes.

“Some say it’s the kind of food, I’m not very sure what causes it, but it’s what people say.”

– Esther (f, 60+, Zimbabwe, asylum seeker)

“So I don’t know what’s the reason about diabetes, but the diabetes, I don’t, if you are eating too much.”

– Awo (f, 40-49, Ghana, asylum seeker)

6.3.2 Access to preventive services

I asked the participants (dependent on age and sex) about breast, cervical and bowel screening (as a proxy for prevention) and also about the Keepwell programme. Though defunded as of 2016, the Keepwell programme aimed to help reduce health inequalities by inviting those between 40 and 64 who lived in deprived areas, and who were registered with a general practice to a health check where they were screened for cardiovascular risk factors (healthscotland.com). All of the participant lived in a Keepwell catchment area. However, not one participant had, to their knowledge, heard of or attended a Keepwell check up. The female participants had all engaged in, or received invitations for breast and/or cervical screening however. With the exception of Keepwell, there was reasonably good awareness of those preventive and screening interventions which were managed through primary care.

“Oh you know, in this country, once you get into the system, you can’t run away. I’ve just had the cervical smear just recently and my results came, they said ‘you’re ok.’ Breast, I’ve had breast... yeah, they keep on reminding you even for the retinal screening and before maybe you forget, you can an NHS letter under your door.” – Melissa

“They always invite us every year. For things like flu jab, family planning, and things like that.” – Hazel

As with preventive care more broadly, general health screening was an entirely new concept; “*That’s a language I never heard, I’d be lying if I said I did*” (Thandi), but many

saw its merits in theory, as a way to cover all bases and reduce the likelihood of a sudden unexpected illness.

“Yeah, this is new. Yeah, this is new. I, I think this is good. Because, you will like, it will not be sudden when you are sick. Because you know yourself, you know what’s starting and what’s going on. You can see, yeah.”

– Asmeret (f, 30-39, Eritrea, asylum seeker)

“Yes why not, it’s very important to our life.”

– Awo (4, 40-49, Ghana, refugee)

Indeed, Awo linked the high rates of illness and death in South Africa, where she was from, to such programmes not existing.

“Oh yeah, lots of people have diabetes. Lots of people. Recently a friend called me, their mum, she was sick, they don’t know what’s – before they realised diabetes, [she] just died. Because to me, I don’t know why, is just – they don’t have everything much to use. Because they are villagers, if they eat healthy food, they’ll eat healthy food. Bad food no healthy, they’ll eat, but they are not doing anything to check what is going on in the body. They’ll just die like that. You know what I mean?”

However, not all of the participants were positive about screening, with suggestions that screening might actually be a mechanism for making people ill (either intentionally or unintentionally).

“But I’ll just think ah, why do they want to screen me? They want to give me another disease again. That is what, that’s my mentality anyway. I don’t want... that’s why I’m not going. Because I don’t know what they do. Because in my country I’ve never done such a thing anyway.”

- Mufaro (f, 40-49, Zimbabwe, asylum seeker)

Though Mufaro’s view was not a majority opinion her feelings raise a concern that individuals may shy away from interventions that they have no prior experience of, particularly if they are in a position where they do not necessarily trust those in authority. Mufaro did not consider screening necessary since she had not been required to engage in it previously, and therefore did not trust those professionals who advocated it, suggesting that they had malevolent intentions.

Tadiwa (f, 50-59, Zimbabwe, asylum seeker) shared similar concerns, in her case, that the breast screening process caused rather than detected cancer. It is possible to see where this concern emanates from, since mammograms carry the same small risk as any radiation. This minimal risk is generally considered to be outweighed by the benefits, however. Tadiwa did not identify herself to be a candidate for a mammogram, not because she didn't believe in screening or prevention in general, but because she considered this particular procedure to be bogus.

“I've read somewhere that I saw, women, when they do the test it's like it's something that affects the cancer cells or it's like it causes the cancer cells to develop or something? I can't remember the rationale behind it.”

While these perceptions run contrary to public health recommendations, it is noteworthy that some health professionals also question the merit of screening programmes suggesting that they can do more harm than good (McCartney 2011).

From the perspective of public health professionals, there was a strong sense that a greater focus needed to be placed on preventive healthcare, and that holistic projects such as social prescribing³⁰ should be central to preventive health strategies. The current focus on preventive health was felt to be insufficient.

Laura, a public health professional was keen to stress the extent to which prevention specifically and public health more generally touched on multiple areas.

“Well it's kind of tied up, all the same isn't it, I mean it's public health is you know, your access to the leisure facilities.”

There was a sense however, that despite this acknowledgement, public health issues were considered in silos rather than as interrelated.

“It's in a silo so you've got smoking cessation, the Keep Well and all that kind of thing, so it's a very mixed bag.”

–Clementine, public health professional

³⁰ Social prescribing is means by which primary care staff refer service users to non-clinical services such as community organisations (kingsfund.org.uk/publications/social-prescribing).

6.4 Conclusions

This chapter explored the variety of ways in which the ASR participants conceptualised health, wellbeing, health practices, and illness prevention. Health was conceived of as having biological, behavioural, and environmental components, and participants switched between these explanatory models when discussing the extent to which they could keep healthy or prevent illness. While all participants (particularly the women) emphasised the importance of health practices such as good diet and exercise, they did not necessarily link these practices with risks for specific NCDs. In all the discussions, intersecting structural and cultural influences were evident.

The complex nature of the first stage of the candidacy framework – identification – was demonstrated through the narratives. Firstly, the participants were at a point of transition between a paradigm in which health was only significant when an individual became ill, and health practices were a natural and unremarkable part of life, to one where individual responsibility for health was paramount. As will be discussed in Chapter Eight, this shift in identification of candidacy to being a conscious and active process occurred at a time when many of the participants had limited autonomy over their lives. The second complexity relates to the existence of multiple candidacies. The ways in which participants switched between biological and behavioural explanations showed that identification of candidacy for one particular health practice (e.g., eating less sugar) did not necessarily translate to identification of candidacy for another practice (e.g., eating less salt). Though not considered in the original Dixon-Woods framework, the notion of multiple candidacies was identified by Mackenzie et al with reference to the idea that individuals might engage differently with different types of services (Mackenzie et al 2011). It is clear that they also identify differently with different types of practices, even if those practices may only be subtly different from one another.

I proceed in Chapter Seven to discuss experiences of engagement with primary care and, in doing so, engage with the latter stages of the candidacy framework.

Chapter Seven: Access to services

Having focused on perceptions of health and wellbeing in Chapter Six, I now proceed to consider engagement both with primary healthcare and with social support. Understanding perceptions around access and engagement is an essential first step towards developing programmes and interventions that individuals will engage with. A focus on primary care in particular is important, because in the UK the majority of preventive services and interventions are delivered through primary care. ASRs (and others) need to be able to access and navigate primary care services with confidence, if they are to benefit from primary prevention. In this section, the significance of the later stages of the candidacy model – navigation, permeability, adjudication, offers and resistance, and operating conditions, are all relevant.

Similar to Chapter Six, the focus here remains on the individual experience, with the structural determinants of my participants' experiences addressed explicitly in Chapter Eight. However, again it is impossible to draw true distinctions between these themes, since my participants' identities and experiences as African refugees and asylum seekers coloured nearly every one of their engagements.

7.1 Access to primary care

Talking to the ASR participants about experiences of primary care raised a number of anxieties and concerns. It is important to note, however, the extent to which all valued the opportunities for healthcare that most felt the UK offered them. Gratitude towards the NHS has also been mentioned in other studies on ASR perspectives (O'Donnell et al 2007:75). Though this may have also related to the manner in which they wished to present themselves to me, ASRs were often concerned not to be overly critical, lest this came across as ungrateful.

“I'm talking here as a human, I'm thinking about other people as well, you know, I think I will be selfish if I'm complaining about the health service, so personally I think the health service is, and also having in my mind where I come from, you know, accessing healthcare is a big thing in Africa so I think yeah, I have no complaints at all.”

– Azzam (m, 40-49, Ghana, refugee)

All the participants emphasised the impossibility of comparing the healthcare they engaged with in Glasgow to that which they had experienced in their countries of origin.

Experiences in the UK were unequivocally better. For some this was because care and medicine were free, for others it was simply because access existed in the first place. As a result, many participants were, at least initially, well disposed to the healthcare system, felt it a privilege, and were willing engagers.

“The services I get because if you take it which way is more, is it the bad or the good, so if the good have more you take good, or bad take more you take the bad, but I think most of the things are much better, I can’t compare with Malawi because in my country you may go and you have no treatment because there are no medicines so I can’t compare with here. Here there is ready medicine, so I can’t, I really can’t say, I am more privileged here than back in my country.”

– Brenda (f, 40-49, Malawi, asylum seeker)

“There is no free like NHS, even there is no doctor or some medicines. Even by your money, when you need it you can’t get it.”

– Fessehaye (m, 20-29, Eritrea, refugee)

As the health board in which the vast majority of refugees and asylum seekers in Scotland reside, NHS Greater Glasgow and Clyde (NHS GGC) has gone to significant lengths to address the health and wellbeing of refugees and asylum seekers (both those still waiting and those whose claims have been rejected). To this end, they have developed specific bridging services and collaborated with third sector organisations such as the Scottish Refugee Council (Scottish Government 2013) to develop best practices in promoting refugee and asylum seeker health.

The public health professionals I spoke to were keen to describe the specific routes through which health access for refugees and asylum seekers was facilitated. At the public health level, the role of the refugee strategy group was discussed in particular.

“So you’ve got the Scottish Refugee Council, you’ve got the British Red Cross, you’ve got all different parts of the NHS, midwifery, health visiting, you’ve got the interpreting service, a whole range of partners that kind of come together to network and share information and under that we have a group that was set up to take forward the kind of actions from the strategy.”

– Mary Anne, public health practitioner

While many positive views were expressed about the primary care system in Glasgow, ASRs' relationships with primary care are more complex than simply positive or negative. In particular, experiences of access to care need to be seen within their particular social and cultural context.

7.1.1 Cultural differences in the production of candidacy

The candidacy journey is one that is socially and culturally constructed (Dixon Woods 2005), both by service users and service providers. It was therefore important to consider the ways in which the participants' engagements with health services and preventive health might be shaped by cultural norms. Cultural conceptions of health are relevant not just in terms of perceptions of health, and identification of candidacy, but also in terms of the particular services that are accessed, and how individuals navigate or adjudicate those services. Taking account of culture is critical in ensuring that healthcare and health research resonate with individuals' lived experiences and can be integrated in meaningful ways (Lancet Commission 2014:1608). This does not however mean just looking for 'exotic' influences on attitudes to care, but at the variety of norms on both sides (service user and provider) that shape approaches. Differences in health service provision between the UK and their countries of origin led the ASR participants to reflect on the different ways in which they engaged with the health service in the UK, and the impact that their previous engagements had had. Differences were noted in the types of care one might seek, and the ways in which one might engage.

“People [in Zimbabwe] rarely go to hospital unless there is something wrong with you which is rare (...) so people like that they don't believe in hospitals so if you tell them to go for a check up they will ask you why, you know, so that's the risky part.”

– Joseph (m, 40-49, Zimbabwe, refugee)

Much anthropological literature discusses the significant variation in understandings of health and illness amongst people from diverse countries and cultures (Taylor et al 2012). There is also evidence that individuals from non-western countries, including those in Sub Saharan Africa, rely on 'traditional' herbal medicines for a variety of ailments, though often in combination with, rather than as a substitute for, biomedicine (Taylor et al 2012:625). Though none of the participants talked about using 'traditional' medicines themselves, my discussion with Thandi (f, 30-39, Zambia, asylum seeker) suggested that this was a relevant issue for at least some migrants from Sub Saharan Africa. It is hard to

say whether it was not mentioned by the other participants because they were uncomfortable talking about this aspect to me, because I was considered to be a member of the biomedical community, or because they did not deem it relevant to their health experiences. The discussion of traditional approaches with Thandi did highlight that individuals will use other sources of authority in addition to biomedical ones in coming to conclusions and making decisions about their health. Individuals might identify themselves as a candidate for, and subsequently engage in, more than one type of health-related practice.

“I think you’re looking at maybe people who come, especially people who’ve come all the way from the rural areas of the African continent. They won’t have the proper medication. Maybe they never even went to a doctor. so they believe in going into the forest, looking for roots to chew to cure (...) we have a lot of people from the African continent that have come directly from the rural areas which they didn’t have proper care, they didn’t have doctors or a huge hospital, there was just like small clinics. And to come and just live here where they’re supposed to be opening up for what their feelings, it’s like they feel ‘I’m going to just kneel down and pray.’”

- Thandi (f, 30-39, Zambia, asylum seeker)

Differing cultural norms or ways of being relate not only to differences in core beliefs about health, illness, or medication, but also differences in the manner in which individuals engage once in healthcare settings. Thandi noted that the ways individuals are required to open up about themselves might be culturally specific and thus make certain people uncomfortable and less likely to engage. Further differences were noted in terms of the ways in which refugees and asylum seekers interacted with health professionals. Again, rather than speaking about her own experiences, Thandi spoke in the third person to describe migrants’ reticence in engaging with health professionals.

“It’s hard when you’re a migrant. I think you go to see your GP and all you are waiting for is to see your GP. There’ll be the whole information you need in front of you and you won’t get it because it’s more like it’s just like some tradition to them that you have to be given that thing (...) It’s the confidence we have in speaking with people, African continent is not really as high as where a lot of you guys come from.”

I described in Chapters Five and Six the ways in which the ASR participants were shifting between two paradigms regarding health and wellbeing, from one in which health practices were perceived to happen as a product of daily life, and health was only considered when an individual was acutely ill, to a paradigm in which individual responsibility for health is regularly emphasised. This was mirrored by a shift from engaging in healthcare services

only when an individual was very ill, to being a pro-active engager. Of course this difference contains economic and structural aspects as well, but is also reflective of differing norms on both sides about the role of healthcare services and an individual's own responsibility, both in terms of self-management and making decisions to engage with services.

As described in Chapters One, Two, and Three, the way in which culture is understood by health professionals has considerable implications for healthcare provision (Castañeda 2010:7). While sensitivity towards different norms and values is extremely important, it is unhelpful to conceptualise culture in an acontextual manner. As will be detailed in Chapter Eight, culture intersects with socioeconomic factors, and it is critical to understand the context of a 'cultural' behaviour.

The public health and primary care professionals also spoke about the role of culture in shaping processes of candidacy, both in terms of identification of illness and subsequently in the manner of engagement. Culture was, in fact, one of the most common lenses through which these participants understood ASR engagement. Both groups emphasised the responsibility that service providers had to ensure that services were culturally appropriate, noting for example that this extended beyond simply ensuring that information existed in the right languages.

“It's not just about a language barrier or anything, it's cultural, there are stigmas attached.”

– Sweta, primary care pharmacist

“Some of the service they might not make sense to Africans or Asians because of their particular cultural identity.”

– Nicholas, public health professional

While biomedicine has been described as a cultural system in itself (Lancet Commission 2014; Kleinman et al 1978), discussions of culture in public health literature tend to focus almost exclusively on the culture of the service user, and the barriers that presents (Castañeda 2015). Though they certainly had no wish to be stigmatising, the ways in which the professional participants discussed cultural norms very much reflected this narrative, with mismatching of expectations due to the difference of the migrant's culture.

“I suppose there is something about people’s expectations as well, and managing those expectations because people come from a different culture.”

-Laura, Public health professional

Professionals did also express more nuanced understandings however, locating problems both within migrant communities and with health services.

“I think there, especially for asylum seekers and BME communities obviously we know and it’s been proven that you know they don’t understand the system, you know even though the settled communities living in Glasgow for past 50 years, or 40 years, or 30 years still you know there are issues when they access our services and partly it’s to do with asylum seeking communities, there is, a lot of the time it’s the communication issues but the same time settled communities have those issues as well even though there are some people who have got, who have been living here and got second or third generation so language is not an issue for them they still, the staff attitude towards them and stereotyping goes on and that impacts how they access a service and how they get treated in the service as well.”

– Marion, public health practitioner

Concurrent with efforts aimed specifically at integrating refugees and asylum seekers into healthcare was an overarching commitment to increasing the accessibility of mainstream services rather than developing too many specifically targeted services.

“For me, the big thing is about mainstreaming and it’s about making sure that our services are accessible for everyone so that would be a big examination of our equalities data, so in terms of our money advice service, I would be expecting a certain amount of people from BME community...”

– Laura, public health practitioner

“I think the biggest challenge is making sure that the information we provide are accessible and the services are accessible as well.”

– Marion, public health practitioner

Primary care staff did not necessarily have the same interpretation, however. Sweta, a primary care pharmacist who had been involved in a now defunded culturally tailored pharmacist intervention aimed at BME communities noted that as soon as people were referred out of culturally tailored programmes, engagement dropped.

“general services didn’t quite work, because as soon as you refer to like mental health or somewhere else, and if there was no communication or bilingual, the

patients wouldn't go, or there would be no engagement either because the understanding wasn't there.”

Individuals do not necessarily transfer their identification of candidacy from one service into another. While efforts on the part of service providers to engage diverse service users are extremely laudable, developing strong links into one service is not sufficient on its own. For individuals who have not traditionally engaged with health services or interventions, candidacy is renegotiated over time and in different contexts.

7.1.2 Physical access to services

Before considering physical access to services it is useful to summarise entitlements to care in Scotland. Scotland extends full primary and secondary healthcare entitlements not only to asylum seekers and refugees, but also to those whose claims for asylum have been rejected (SRC 2013). Efforts have also been made to simplify the process for asylum seekers accessing GP services in Scotland. NHS GGC has an asylum coordinator who assigns a GP practice to all asylum seekers where they can register (ibid). Before registration takes place, a nurse provides screening and care to asylum seekers through the asylum seeker bridging team. This process was relatively simple when all asylum seekers were housed in the Red Road³¹ flats, but has become more complicated now that asylum seekers are dispersed throughout Glasgow.

“I would say we were in a fortunate position when we had the initial accommodation some respects people would say ‘oh it was dreadful accommodation in the Red Road, but because it was a single site with the health team there based with the housing provider we were fortunate because we’ve never had that model down south it’s always been a kind of dispersed initial accommodation so we are now having to get to grips with the English model because that’s the way it’s going to be now which presents more challenges I think for X’s team because you’ve got to get people to where they get their health screening appointment.”

– Mary Anne, public health professional

NHS GGC’s efforts in this regard are important, since challenges registering with general practices can provide a significant barrier to regular healthcare for refugees and asylum seekers (Stagg et al 2012). Furthermore, this process takes the initial responsibility to

³¹ The Red Road Flats were a complex of high rise flats in North East Glasgow built as innovative social housing in the 1960s. The flats were a site of numerous social problems, however, and it was eventually decided to demolish them. This was completed in 2015. In the 2000s, asylum seekers dispersed to Glasgow were housed in one of the blocks (redroadflats.org.uk).

navigate a complex system out of the hands of ASRs and places it on the health system. This creates local operating conditions that facilitate access to care. Cheng et al, in a systematic review of refugee experiences of general practice in countries of resettlement identified the physical process of registering as a significant barrier to use of primary care by refugees, along with line managers, poor doctor-patient relationships and nonalignment of expectations (Cheng et al 2015: 171). In contrast, all of the ASR participants, except two – Robel (m, 30-39, Eritrea, asylum seeker) who was homeless and did not have regular access to a GP, and Mercy (f, 30-39, South Africa, refugee), whose story is discussed in Chapter Eight – described a smooth, or at least unremarkable process of first registering for a GP. This suggests that NHS GGCs efforts to ensure access were relatively successful, though of course other ASRs may not have had the same experiences as those in this study. Nevertheless, NHS GGC's success in largely mitigating this problem can provide a useful model for other dispersal cities.

Many participants continued to describe their experiences with accessing GP services as straightforward, noting access to a GP as one of the most positive aspects of their existence in Glasgow

“The availability of health services, like GP services, that's one other reason I like this place, my GP is just around the corner, so easily accessible.”

– Priscilla (f, 30-39, Malawi, asylum seeker)

Audrey: If I'm not feeling well? If I'm not feeling... I just go to my GP. Uh huh. I talk with my GP and she will prescribe whatever in the way I'm feeling, what is a problem to me.

Anna: And is it easy to get an appointment at your, at the GP?

Audrey: Yeah, I just call, give them the call and they give me an appointment. If it is an emergency I just tell them 'now I'm not feeling well'. They just accept it.”

Audrey described her GP as easy to access and the natural port of call when feeling unwell. This demonstrates that positive experiences can cement identification of candidacy for a particular service.

Most participants also lived only a short walk from their GP, making them easily navigable from a geographical sense, with Priscilla, Brenda and Melissa all pointing their surgeries out to me as we walked around the neighbourhood.

Physical access was not entirely straightforward however. While the participants were all registered with a GP, this did not mean that they were necessarily able to access care in the way that they wished. It is useful to note here that as numbers of refugees and asylum seekers increase in Glasgow, they are registered at an increasing number of GP surgeries, some of which have limited prior experience of these populations. *“Some of the GPs they haven’t been doing it for a long time might be a less patient, a bit more obstructive but as I said there are some excellent GPs out there and a lot of them will promote about making sure that they are doing the right thing for people”* (Ben, primary care nurse). Access complications (or perceived complications) related to a variety of factors including misaligned expectations (particularly around appointment booking systems) and difficulties related to specific experiences the participants faced as ASRs. Importantly, it was not just health professionals with whom interactions were relevant, however, but all individuals working in the primary care space including reception and administrative staff.

Waiting times and booking processes for appointments were singled out as a cause for concern. The extent to which these concerns differ from those of the general population is unclear, since NHS waiting times have been a public concern for some time. They do however indicate a lack of clarity on how appointment processes operate, which lessened the ability of the participants to seek the care they required. While general practice surgeries differ in their booking processes, a primary concern amongst the participants was the time it took to secure an appointment. If they tried to book an appointment when they were unwell, they were often unable to get one until several days later, by which time they had recovered. This perception may tie into the reason that migrants are more likely to use A&E services than other forms of care (Graetz et al 2017). As the barriers to being seen by a health professional in that setting are lower, the service is considered to be more permeable.

“I think the other thing is there is too much waiting time in here, you know if you have to go to the GP and make an appointment and it’s full I come tomorrow, no maybe in 2 weeks’ time.”

– Joseph (m, 40-49, Zimbabwe, refugee)

“Let’s say if you come today they will say, for example, next week, which is not really ideal.”

– Hagos (m, 20-29, Eritrea, asylum seeker)

“Yeah I would love to be seen when I came on the day when I have pain, but normally, it’s not the case, it takes a week and maybe the pain has gone by then.”

- Tadesse (m, 40-49, Eritrea, asylum seeker)

In addition to being an irritation, Mebrahtu (m, 30-39, Eritrea, refugee) considered waiting times to have seriously affected his health. Mebrahtu, who had been dealing with numerous health issues since he had been in the UK, had become concerned by the amount of time it had taken to be seen and followed up by primary care. The effect of this was that he no longer trusted the recommendation of his doctors to have an operation. A succession of negative experiences altered the candidacy process to the extent that when offers of care were eventually made, he was not convinced that they were the right option.

“I didn’t get maybe the right medication for them, it’s been very frustrating and now, just recently they said they are going to do like an operation for me, but I am not too sure, I almost gave up on them, and suddenly to say they are going to do surgery makes me think, I mean I am doubting...”

Mebrahtu’s inability to have his physical concerns addressed in the UK had had psychological as well as physical implications.

“My health has actually gone from bad to worse since I come here and this is mainly because I was very positive and optimistic to get medical help when I come to the country, to improve my life but this was not the case at all and it affected me mentally. I think about it. I mean depression and a lot of stress about it.”

Kovandzic et al suggest that poor mental health could have knock-on effects in terms of individuals’ capacity to either recognise or assert their candidacy for health services (Kovandzic et al 2011:768). For Mebrahtu, however, the opposite was true. Having been unsuccessful in his attempts to assert candidacy, his mental health was negatively affected. Abbott et al noted a similar occurrence in their study of access to care by women in prison. When the women’s health concerns were not taken seriously by healthcare providers, they considered their mental health had suffered (Abbott et al 2017:7).

As described further in Chapter Eight, candidacy was also impacted by the participants’ identities as ASRs. Mebrahtu (m, 30-39, Eritrea, refugee) described how even the process of booking an appointment presented a barrier for asylum seekers who might not have the available funds to telephone for an appointment. This demonstrates how asylum-related

barriers are present at every step of the candidacy process. Individuals may be unlikely to assert their right to candidacy unless they are very ill.

“If you are asked to phone to arrange an appointment at the GP, probably an asylum seeker or a refugee, you don’t have enough credit to make phone calls.”

A concern that was raised in one of the Ketso groups, and repeated by public health professionals, was that refused asylum seekers and undocumented migrants might be concerned that a healthcare professional would disclose their status to the Home Office and thus choose to stay away from healthcare and other services, with deleterious effects.

Participant A: “I was in a class yesterday and they were talking about how people not even register with a GP because they are thinking that they are going to ask me about my immigration status or once I get my name highlighted in whatever system it's going to spread you know I'm going to be known in the system instead of preferring to be underground it's like I'm going to bring attention to myself so people generally just keep to themselves so people will not register with GPs they will not get into contact with any services and then maybe their health can deteriorate.”

Participant B: “That is what I'm talking about the fear of trust, the people are not trusting anybody especially when you know you, you don’t know who you’re talking to and you think everybody you talk to, to be there to maybe, there's a word I'm trying to look for, it will be there just for your name to be forwarded to maybe immigration or something and even if you were asylum seeker at that time some of the things that you see and you think everybody is an enemy or you don’t, you don’t trust anybody so in any case you'll be stressed on what can I do, who do I talk to, I don’t trust anybody and at that time you get depressed, you get stressed out because you do not trust anybody.”

(from Ketso session 1)

Nicholas, who worked in a public health organisation was keen to stress efforts to ensure this wasn’t the case: “*am talking now from experience of working with people who have got HIV because we talk with people and then just this is a myth people have in their mind so we try to work around that to tell them that it's not any connection with the Home Office and your health services, that can encourage people to access the health services*”. It is unsurprising, however, given recent admissions that the Home Office has been trying, at least south of the border, to obtain information on patients’ migration statuses from the NHS (doctorsoftheworld.org.uk), that undocumented migrants would have this concern, and health professionals would have difficulty allaying such worries. Practices such as this

directly undermine the notion of a right to health and healthcare, instead using citizenship or other markers of right to remain as a basis on which to offer or deny care.

Difficulties in access for undocumented migrants can be compounded by GP surgeries removing refused asylum seekers from their lists, even though this is not legally required of them, so those who do continue to try to access healthcare may be turned away

“I know one of the problems we’ve had is if someone’s case is refused sometimes the GP practice will then seek to remove them from their list.”

– Mary Anne, public health professional

7.1.3 Experiences of engagement with professionals

Moving from physical access to engagement with health professionals themselves, a range of feelings from total satisfaction, to deep disappointment were expressed. For the most part, in keeping with the aforementioned sense of gratitude towards the NHS, many participants talked very positively about their experience with primary care.

“From my experience of the visits, that I have made to the GPs here in Summerbrook, they really give you a long time, they don’t rush you. Yeah, they listen.”

– Tadiwa (f, 50-59, Zimbabwe, refugee)

“My GP (...) he has been so honest and helpful and caring.”

- Azzam (m, 40-49, Ghana, asylum seeker)

This did not mean that the participants did not voice their concerns, however. These ranged from general preferences for certain doctors over others, to more serious worries related to the proficiency of medical staff and the ways in which participants were treated. Although she recognised that GPs could not be experts about everything, Priscilla (f, 30-39, Malawi, asylum seeker) expressed concern that her GP was not more aware of particular conditions.

“The way they are like being too cautious about that, you are like ‘no it’s not going to be passed onto you like that, so even sometimes I think hey say you think that you are not really up to date with this particular illness is all about, you know, so I don’t know how it is possible to increase awareness of I don’t know, they don’t, there are so many illnesses out there you can’t say you want all the GPs to be experts in everything, I don’t know but you get instances

where you know they are not aware of this particular illness and it kind of causes problems.”

Concerns around levels of experience, which may relate to differences in understandings of the role of primary care were also noted in a study by O’Donnell et al of asylum seekers expectations of general practice (2008:5).

Ben, a primary care nurse similarly discussed the hugely varied expectations of the health service by different refugees/ migrants, underscoring the point that expectations cannot be taken for granted.

“The expectations will differ wildly (...) your Sudanese boys who are just happy someone has paid attention to them (...) but you might get a wealthy Iranian who has access to healthcare all their life.”

While individual healthcare professionals will of course differ in the quality of care they offer, Ben further suggested that there was a large gulf between those GPs who were positive in their attitudes towards asylum seekers and those who were more obstructive.

“Some GPs are brilliant and some are generally quite awkward and uncommunicative and some are difficult.”

Negative experiences of access and engagement have a number of implications. First they indicate an area where the NHS may have an educatory role, both for professionals and for individuals with less familiarity with the NHS. The second implication relates to the knock-on effect a negative experience may have. This might be particularly problematic depending on what the negative experience is attributed to. Candidacy is a constructed process and one that can shift over time. A negative experience might diminish an individual’s willingness to assert him or herself the next time they are in need of medical attention, or lead someone to assume that certain services are not designed with them in mind and are therefore not an option for them.

The ways that the participants discussed negative experiences of healthcare demonstrated how one bad experience has an effect on their willingness to engage further or maintain faith in the services they were offered. After Elizabeth’s difficult experience in an A&E department, she had resolved not to return to a hospital even if she needed to. In a sense, she had been persuaded that such services were not for people like her.

“No. Even if I’ve got like, now, a very painful like (...) I’m not going to call an ambulance, I’m not going to do nothing.”

An important aspect of the candidacy framework is that it considers the process of accessing healthcare from the perspectives of both the service user and the service provider. It is not only service users who identify themselves as candidates for a particular treatment or service, but also the provider who makes a judgement about what the service user needs. This might be particularly important in relation to preventive care when, as described in Chapter Six, ASR patients might not have encountered such a concept before. Melanie, a GP, noted that it was easy to make assumptions about what a refugee or asylum seeker’s most pressing need might be (e.g. secure accommodation) and thus overlook health issues that might be concerning or important, though less immediate.

“I think it's a really interesting one and you know so the way you foreground an aspect of their needs.”

Although Melanie’s perspective is that of only one doctor, this recognition is important, since implicit understandings about the needs and capabilities of service users influence the ways that services are designed (Bradby et al 2015:11).

7.1.4 Interpreting

For those participants with limited English, both access to and engagement with care were further constrained. NHS GGC has an in-house interpreting service, providing interpreters in person, or if necessary by phone, both in and out of hours (equalitiesinhealth.org). There is no cost imposed on a GP practice or hospital for use of this service. Securing an interpreter for a consultation should be (and often is) reasonably straightforward. However, challenges appeared to occur both on the supply side (e.g., in terms of availability of minority language interpreters) and the demand side (e.g., in terms of awareness about what was available).

The participants varied greatly in terms of their English language usage, encompassing the entire spectrum from those for whom it was a first language to those who spoke no more than a few words. The extent to which language impacted on their healthcare-related experiences varied also. Language was considered a barrier by many, though, including those who, to me, appeared to have an impressive command of the English language. Language related challenges presented themselves at every stage of the candidacy journey,

causing difficulties at an organisation level as well as having a qualitative effect on consultations themselves.

For those who spoke little to no English, challenges associated with healthcare engagement started before the consultation itself, since even booking an appointment posed a challenge. This was noted by participants, “*sometimes, like if people can’t speak English they put you on hold*” (K002 participant), and was a source of concern for those working in public health, who were keen to express NHS GGCs commitment to interpreting at all stages, but were concerned that this was not carried through at all GP surgeries. A service that many would consider to be relatively easy to navigate becomes far less so if language barriers complicate the booking process. Of course, within already busy and pressurised surgeries, the added step of planning for and booking an interpreter can be problematic and requires extra forethought.

“If someone turns up, they are just kind of given a form but that’s not their kind of initial health screening, they are still entitled to interpreting but sometimes maybe receptionists are saying this isn’t your appointment.”

-Mary Anne, public health specialist

“What’s great is that now they’ve got little language cards so now that... and obviously if somebody has not got English we can take... not everybody knows about it, the language cards and there’s that issue that there are language cards that are available so obviously if there is someone that is Farsi-speaking or they’re speaking... and they can’t communicate in English, they would take that and give it to the receptionist and see what language they would like the interpreter to speak when they book it, so they’ve got sort of booking language cards, which is really helpful, I think.”

– Clementine, public health specialist

Challenges also existed in terms of health-related correspondence. For Asmeret (f, 30-39, Eritrea, asylum seeker), who lacked confidence in English, receiving screening letters in the post had caused her considerable confusion and so although she wanted to attend for a cervical smear, she was unaware of how to. Asmeret was unable to move beyond the identification stage of the candidacy process due to this constraint.

“I don’t know how, how to communicate with her. I don’t know the place. They sent me one letter for scanning. Still I’m not going.”

Various concerns around supply of interpreters were raised by the participants. While there is of course a difference between conversational and clinical English, it was unclear at which point a service user was entitled to an interpreter. Osman (m, 30-39, Eritrea, refugee), who spoke at length about an unsatisfactory experience at a hospital, felt he had been denied an interpreter because of his basic conversational English, even though his capacity for more technical discussion was circumscribed. In this way, his agency in the encounter, and his ability to advocate for himself, was reduced.

“I know myself, I don’t speak English very good but they say to me you speak English, there is no interpreter, so what can I do? I have to help myself.”

– Osman

Elizabeth (f, 40-49, Zimbabwe, asylum seeker) noted a similar concern:

“Sometimes English, you can’t explain the way how you are feeling really because of English, you don’t know the words to put”.

An additional supply issue related to the type of interpreters who were provided. Participants had experiences of being provided with interpreters who either spoke a different dialect, or in one case an entirely different language.

“Sometimes they never bring you the language that you speak, they might bring you Arabic speaker and my Arabic and the interpreter’s can be completely different.”

- Tadesse (m, 40-49, Eritrea, asylum seeker)

“I have for example three interpreters come in to interpret for me in the past year but they were all Ethiopians so I was basically stuck in between, I was not able to reject them because I was just worried about my health condition so all the delay probably could be because of them, they were not able to give exactly what I was saying and what the healthy professionals were saying so this is really a very serious issues.”

– Mebrahtu (m, 30-39, Eritrea, refugee)

Mebrahtu’s comments about how he was offered Amharic speaking interpreters, when he himself spoke Tigrinya illustrate the power an interpreter and the interpreting service has to affect the quality of a consultation, and the lack of agency an individual, who is already concerned about their health, has to challenge it. Rejecting a professional requires a significant amount of social capital that might be difficult even for someone who is accustomed to the way that the health service runs in the UK.

It was recognised by NHS GGC that there were insufficient numbers of interpreters for certain languages which may explain, though not excuse, the mismatching of interpreters:

“There is still not enough Somalian interpreters.”

- Marion, public health specialist

As this demonstrates, issues around interpreting in healthcare are not simply a matter of supply and demand, but also about the impact on the quality of consultation and the relationship between patient and practitioner. For the participants who did not have conversational English, the clinical encounter itself was infused with an additional layer of power dynamics related to the existence of a third person – the interpreter – in the encounter. For both patient and practitioner, the presence of an interpreter was considered an impediment to an adequate consultation, due to everything being mediated through a third party (whether in person or on the phone):

“You get some very good interpreters and some interpreters that you are not 100% sure if they understand what you mean (...) patient has explained to them in the waiting room before they come in so that they just sit down and tell the whole lot and you are almost having a consultation with the interpreter and they are answering questions on the patients behalf and you don't really know whether that's been discussed before or after or are they just interpreting what the patient has actually said and that can be good but it also can be bad because you don't really know how much of it you actually gain through and how much of it is the interpreter just saying this is what's happening basically.”

– Paul, GP

Before we started talking about interpreters, I asked Tadesse whether he felt that his GP understood his needs. His response indicated that he felt the doctor's capacity to do this was compromised by phone interpreters, whose translations he did not trust.

“Yeah, I think the problem here is it's always done through interpreter, through telephone and my feeling maybe my message not being conveyed, yeah, properly, probably miss something so that's why I'm a bit concerned about this because it's not one-to-one so you never know maybe it's a half problem that has been transferred so that's why there is some delay (...) I don't think my issue has been addressed properly, because there is always a problem with interpreters.”

Greenhalgh et al, in a study of service user/practitioner relationships in interpreted consultations use a Habermasian framework to describe interpreted consultations as a ‘wicked problem’, in which full and open communication is close to impossible due to the

increased constraints, and change of roles, when an additional person is introduced into the relationship (Greenhalgh et al 2006).

Greenhalgh et al note that the presence of an interpreter in a consultation further shifts the power balance away from the service user towards the professional. Mebrahtu (m, 30-39, Eritrea, refugee), in fact, considered the power to lie almost entirely at the hands of the interpreter who could interpret in a way that facilitated the consultation, or could choose not to with serious consequences. As far as Mebrahtu was concerned, he had no role in the candidacy process at that point.

“Once again all the power is in the hands of the interpreter, if he’s good he will give a very clear message, if not, completely wrong message and that affects people’s health and people’s life. But it’s nothing to do with the health professional, health professional are there to do their job however the interpreter has got the key in his hand so they can either destroy somebody’s life or they can the opposite. It can make somebody’s life better.”

- Mebrahtu

Janine, a public health specialist also expressed concern about the effect of an interpreter on the relationship dynamic in a consultation, given the power an interpreter has to determine what information is imparted and what is not. This, in turn, could weaken the communication between doctor and service user.

“Sometimes people want the same interpreter (...) then the interpreter becomes the gate person for that person and then can get lost in translation.”

Lastly, one participant called into question the skills of his interpreter, and thus the quality of the consultations he was receiving, as he did not feel his interpreters possessed appropriate medical knowledge. In this instance he felt himself to be receiving a lower quality of care than if there had been no need for an interpreter.

7.2 Access to social support

Social support, mediated through community organisations, played a significant role in the lives of many of the participants and was considered an important factor in keeping them healthy. Through these organisations, they were able to establish, amongst other things, a sense of community, a route out of isolation, and a link to health promoting activities³².

³² It should be noted that my recruitment was all conducted through community organisations and so the sample was skewed towards individuals who benefitted from them particularly.

Non-health services, including education and other public services, have also previously been explored through the lens of candidacy. Mackenzie et al conducted a critical interpretive synthesis to test the utility of candidacy as a concept for understanding journeys through public services. They found it to be a useful tool to explore notions of multiple candidacies; individuals may identify differently with different services, and these different identifications have the potential to affect each other (Mackenzie et al 2012:9). It is therefore useful to explore social support not only because it affects health and wellbeing in broad terms, but because engagements in the social sphere may impact engagements with health services and may play a role in facilitating engagement with preventive services.

7.2.1 Role of community organisations

For many of the participants, engagement with social support in Glasgow had been facilitated by the plethora of community organisations that provide different opportunities to refugees and asylum seekers. Although the participants participated in these to varying degrees, with some significantly more isolated than others, they provided a bridge to other integration opportunities.

Mebrahtu (m, 30-39, Eritrea, refugee): Yeah I have been involved with a wide range of communities such as X integration network, the Eritrean community, the X centre and X organisation so I participated in different social events and cultural events

Anna: Did you find it easy to get involved when you first arrived?

Mebrahtu: Yeah. The organisations that I mentioned they are very helpful, I have to say like they are a bridge, they, if you are a new person and they are a bridge like to be integrated to the local community so their role is very important.

In the absence of a sense of support from the UK government, Priscilla (f, 30-39, Malawi, asylum seeker) noted the role that community organisations can play in ensuring that people feel anchored and able to assert some control over their lives.

“Lots of different groups that are kind of like targeted towards migrants, or led by migrants, so it kind of acts like a backup system really. Yeah you don’t get that in most of the cities, yeah, so that kind of makes Glasgow a good place to be in.”

The diversity and open nature of community groups together with the fact that so many were directly targeted towards ASRs had an influence across all stages of the candidacy journey. ASRs were more likely to identify services as relevant to them, services were easier to navigate and permeate, and offers of support or service access more likely to be taken up. Additionally, community groups paved the way for ASRs to participate in other activities, such as exercise (as described previously) demonstrating that a smooth process to access one service can shape candidacy for another.

Though prosaic, one of the most significant ways in which community organisations contributed to wellbeing, was through the opportunities they offered the participants to make friends with others who were in similar situations, reducing isolation and extending support networks. Awo and Thandi talked about the people they had met through community organisations and how they provided a support network for dealing with difficult times.

“Everyone bring their different own cultures, and different food, different music. Like it reminds you about your culture and then you are happy then, that you can see someone smiling. ‘Oh I remember this is a song from my country. This is what I eat from my country.’ That’s a bit healthy to see someone smile.”

– Thandi (f, 30-39, Zambia, asylum seeker)

“Very, very tough but we manage to make it because if I say, Glasgow is lovely (...) we need people, we laugh, we joke, we talk, we, at times, we get angry, we say so many things there but after we come back to our self and we go with this, so yeah. And it’s like multi-culture, everybody, like, every tribe is in. So is, is mixed, yeah, you meet different kinds of people, you know, is so, I don’t know how to say, so amazing.”

– Awo (f, 40-49, Ghana, asylum seeker)

7.2.2 Role of volunteering

Asylum seekers are not allowed to work (<https://www.gov.uk/asylum-support/what-youll-get>) and thus do not gain the potential sense of purpose and wellbeing that a job might provide. Many do not have regular activities with which to fill their days. Volunteering, which many participated in, was felt to provide a sense of responsibility and purpose, further increase people’s connections to others, and have an extremely positive effect on mental health. Volunteering allowed people the opportunity to make a useful impact in the community and increase their skills.

“I now have a lot of contacts with people. And also through, you know, all the voluntary work that I do, like the choir and just going places. Like I also volunteer at X organisation so you get, like, when we do trainings like the mandatory trainings I meet a lot of people and we also go out to the community, help the community.”

– Tadiwa f, 50-59, Zimbabwe, asylum seeker)

Mercy and Audrey both cited volunteering as having helped to bring them out of depression and consequently, it had, and continued to have, a profound impact on their lives. Audrey spoke in particular of the various benefits that volunteering afforded her from the social aspect to the fact that she was able to contribute.

“I’m being voluntary at X organisation, so I’ve got chances to talk to people, chances to meet people. I’m gaining, I gain from those voluntary, it’s working in the community, talking to people, have fun with people, doing all sorts of things. It’s helping me a lot, because all the time I applied to have this house I was so depressed.”

– Audrey (f, 60+. Zimbabwe, asylum seeker)

“Yeah it helped for my depression as well. Because I don’t know, if I didn’t volunteer...”

– Mercy (f, 40-49, South Africa, refugee)

7.2.3 Navigating support

Because all the ASR participants came through a community organisation, the extent to which they as a group were able to navigate social support is not necessarily representative of the extent to which refugees and asylum seekers are able to do this in general. Even amongst the participants there was a significant difference between those who were connected to a large number of services and those (mostly single men) who existed largely on the margins. Robel (m, 30-39, Eritrea, refugee) who had been homeless for many years had not been to, or heard of, the Glasgow integration networks. Similarly, Hagos (m, 20-29, Eritrea, asylum seeker), said he had not been to any of the integration networks, the Scottish Refugee Council or other community organisations. When I mentioned that they might be able to provide him with support he responded that *“Yes that’s a good idea but I don’t know I’ve never been to these places”*. Lynam and Cowley, in their exploration of marginalisation as a determinant of health argue that those individuals who have fewer networks are likely to face more difficulties than those with larger networks, even if their financial means are comparable (2007:147). In this way, processes of marginalisation and

‘othering’ themselves become determinants of poor health outcomes. Such marginalisation runs the risk of becoming internalised, meaning people are less likely to identify themselves as candidates for opportunities (Lynam & Cowley 2007:147). This is a similar phenomenon to Kovandzic et al’s suggestion that having a mental health issue can diminish candidacy for other services due to effects of stigma and ‘othering’ (Kovandzic et al 2011: 771). This is particularly problematic for encouraging health practices that require active engagement and assertion of candidacy.

Mackenzie et al raise a concern that services which are targeted towards a general population risk increasing inequalities since those with resources will access the service while others will not and the gap between those two groups will increase (Mackenzie et al 2012:2). While ASR community groups do already target a specific sector of the population, the fact that there were such significant differences between those participants who were engaged in community groups and those who were not suggests that consideration of more appropriate approaches to engagement is required to fully engage all ASRs.

Concerns that ASRs were being missed by community organisations were also raised by public health professionals. In particular, it was suggested that while the majority of support was directed towards women and young children, there were a large number of single men who were poorly provided for. Certainly many of the men I interviewed were in the most precarious positions, and least likely to have engaged in a variety of public services. A second concern related to the geographical distribution of support networks. While the integration networks provided much needed assistance to many of the participants and to many other refugees and asylum seekers in addition, concern was raised that the geographical location of the networks did not match up with the geographical location of most of the refugees and asylum seekers in Glasgow. Many (though not all) of those I interviewed did indeed travel considerable distances to get to integration network meetings.

“We have been working for a number of years with integration networks but they haven’t been terribly well organised or functioned particularly well and we’ve been trying to work to change things. Just an example would be that there was a misconception round about oh it’s all families and it’s not all families. The stats shows it’s very much young men and you know some of the integration networks were thinking well we just really need to link the schools and they don’t so that’s been a bit of a challenge (...) the big housing stock is no longer there and people are dispersed integration networks haven’t quite caught up with the you can’t just work in one area, you have to seek out and

look to see where your population is so those have been some of the challenges.”

- Laura, public health professional

Concerns about the operating conditions in which social support is accessed are complex. It is of course important that services identify the full range of individuals who might benefit from a service and develop strategies to engage those individuals, rather than leaving it to the individuals themselves. However, the economic context within which many statutory organisations (and indeed public health bodies) work must be noted. The organisations I engaged with operated in highly constrained funding environments and often did not know if they would be able to continue once the current funding period ended. Criticisms about non-statutory organisations must be considered in this light. They also demonstrate the importance of a range of bodies sharing responsibility for ASR provision so that constrained funding environments do not increase asylum seeker vulnerability.

7.3 Conclusion

ASR participants discussed mixed experiences of accessing primary healthcare. Experiences of the early stages of access – being registered with a nearby GP – were largely positive. This was likely due, at least in part, to the fact that NHS GGC had taken on part of the work of identifying and asserting candidacy by aiming to ensure that ASRs were all registered with a GP practice. Efforts made by NHS GGC created supportive operating conditions in which ASRs could engage with primary care. The responsibility of NHS GGC to do this was emphasised by many of the primary care and public health professionals. While, for many, positive experiences continued after initial registration a number of barriers presented themselves. These included barriers related to organisation of GP services and the mismatching of expectations, and barriers related to communication, both for those with close to no English and for those who struggled with the technical nature of medical language. Not considered here, but discussed in Chapter Eight, was the impact of discrimination and ‘othering’ which both directly and indirectly impacted on candidacy.

ASR participants were negotiating a new form of candidacy in a setting where services were freely available (in theory), and health was not considered as a crisis but rather as something to engage with proactively. At the same time as changes were occurring in the

ways that health and care were considered, individuals were in transition to a setting in which they were vulnerable to poor health on several levels. This is considered in detail in Chapter Eight, as the analysis moves from individual-level perceptions to the structural factors that shape those perceptions.

Chapter Eight: Determinants of refugee and asylum seeker health

Following the path of the candidacy process, from identification of oneself as a ‘candidate’ for a service, intervention or practice, to the point where that practice is enacted or engaged with, the first two chapters of this results section have explored participant perspectives on what it means to be healthy, how one might prevent chronic illness, and what experiences of service engagement have been. Although my primary focus in those two chapters was on the individual experience, what was clear throughout all the participants’ narratives, and through the presentation of the results, was the extent to which attitudes, experiences and practices were shaped by the broader social, structural, and political environment in which they were embedded. Therefore, it is crucial to look at the broader context in which the participants engaged in health practices, and examine how aspects of that context might have conferred particular risks on them and limited their agency to respond. Expanding investigation outwards from candidacy and drawing on the theory of structural vulnerability (as elucidated in Chapter Three), the focus here is on ‘how a host of mutually reinforcing economic, political, cultural and psychodynamic insults that dispose individuals and communities toward ill health are embodied’ (Quesada, Hart and Bourgeois, 2011 in Castañeda 2013:95).

I explore here, in this final results chapter, the ways in which the status of asylum seeker (for some) and refugee (for others) conferred particular risks (and conversely sometimes protections) on these individuals. While some of these factors have relevance for other socioeconomically disadvantaged and/ or ethnic minority populations, others are specific to the experience of being an asylum seeker or refugee. Those aspects that are discussed here are: the impact of the asylum system, the political context around asylum and migration, racism and discrimination, poverty, and the social environment in which participants resided. It is important to note that although reported separately for clarity, these aspects intersect with and compound one another, and neat distinctions cannot be drawn in reality. This chapter explores how structural determinants impacted not only on how healthy the participants felt they were, or how much they were able to engage in preventive health practices, but also what health meant to them, and what services they felt were, or were not, designed for them.

8.1 Impact of the asylum system

That the asylum and immigration system itself acts as a determinant of health (and should therefore be a focus of study) is emphasised both by Castañeda et al 2015 and Fleischman et al 2015, who promote a determinants-based approach in migrant health research. This view was reinforced by my research. For those participants who were asylum seekers, immigration status, through a multiplicity of channels, acted as a determinant not only of wellbeing, but also perceptions of health and access to/ engagement with care.

‘It’s easier when your immigration status I think has been resolved because the barriers and the restrictions which are there. People that I’ve known to have made it they’re just... they’re not really what they used to be but they’ve just changed to accept the situation and they’ve managed their health, but had it been like they had proper support without these restrictions they’ll be more healthier. We will be more healthier.’

- Thandi (f, 30-39, Zambia, asylum seeker)

The experience of the UK asylum system compounds what for many has been an extremely difficult journey to the UK, both physically and mentally. Although I did not ask about the reasons participants came to the UK explicitly, many did describe shocking and distressing experiences. As Ben, a primary care nurse noted, that people have emerged from these experiences at all can be hard to believe.

“And sometimes when people tell you stuff about how physically how they got here, a lot of time it’s seems unlikely, (...) a lot of times it’s really, really horrific.”

More than past events however, it was the experience of seeking asylum in the UK that coloured almost every single participant’s narrative. Having the status of ‘asylum seeker’ impacted on every aspect of existence from understandings of what it means to live a healthy life, to how individuals engaged with the community around them, and how they experienced accessing health services.

Many participants, even those who had acquired refugee status spoke with heightened agitation about their experiences in the asylum system. Awo (f, 40-49, Ghana, refugee), now happily settled with her son, became particularly distressed as she discussed this part of her experiences, repeatedly describing the process as a “*nightmare*”, and directly alluding to the physical impact explaining that “*It’s make mental stress for everyone, you be sick*”.

As described in Chapter Two, research by Kearns et al used longitudinal data to compare the health of ASRs in Glasgow to that of white, Glaswegian individuals living in the same community (Kearns et al 2015). They noted that the longer an individual remained an asylum seeker the worse their health became, with this health disadvantage remaining even on receipt of refugee status. Participants described to me the various pathways through which they were affected as asylum seekers, all of which left them structurally ‘vulnerable’ and placed them in a space of greater risk for poor health. As discussed below, seeking asylum (i) became the central priority, (ii) left participants in a perpetual state of uncertainty, (iii) dehumanised them, and (iv) impacted on their experience of place.

8.1.1 The asylum process as all consuming

One way in which the asylum process was detrimental to health and wellbeing was in the manner in which it preoccupied individuals so that other activities, including those that promote wellbeing, became less of a priority. With the stress of an undecided asylum application, the capacity to prioritise one’s health was severely undermined. This was displayed in participants’ narratives both through the ways that the notion of a healthy life was conceptualised and also through what activities were considered to be within reach.

When I asked participants the question of what living a healthy life meant to them, many, particularly those in the most precarious positions, talked about the importance of having settled legal status. This points to two issues. The first is that being ‘well’ was conceptualised far more broadly than biological health and the second is that for people to take an active interest in their biological health, a basic level of stability and security was a prerequisite.

“In order to live a healthy life, first of all you need to have your papers sorted which enables you to work and to have to go for further education for example, even to have like proper medical help.”

– Tadesse (m, 40-49, Eritrea, asylum seeker)

It is not legally accurate that being an asylum seeker precludes access to medical care. However, while he was awaiting his status, Tadesse was placed in a psychological space where activities essential to wellbeing were considered out of reach. He did not consider the work that would be required to actively engage with his health to be part of the life of an asylum seeker and this put him at greater risk of poor health.

Robel (m, 30-39, Eritrea, destitute asylum seeker), who spent his nights in a homeless shelter responded similarly, bringing up first his immigration status and then his isolation from his family when asked what health meant to him.

“Yeah I think the most important thing is for my papers to be sorted to get status, but I don’t have any issues apart from that (...) yeah it’s been more than 12 years without paper so I would love to see my family which is very important thing and to get a job, to get my, I mean peaceful, to get peace basically and yeah to get rest because it’s not been easy.”

Though Robel’s prioritisation was entirely logical, the way that asylum seekers and destitute asylum seekers are obliged to live while waiting for status may have implications for their physical and mental health in future years (Kearns et al 2017). Whilst at least in the UK citizenship or legal status should not preclude a right to healthcare³³, it is clear that asylum seekers, and particularly destitute asylum seekers are precluded from living in a manner or environment that provides the potential for good health (Keith & van Ginneken 2015).

As noted in Chapter Six, the ASR participants did talk about the role behaviour as fundamental in shaping health outcomes. However, there was recognition that, as ASRs, their capacity to engage in health-promoting behaviours was constrained. One of the most significant reasons for this constraint was the stress they were under due to the asylum process.

Priscilla (f, 30-39, Mozambique, asylum seeker) talked in detail about the health practices she did and did not engage in throughout the course of our interview. In addition to mentioning the time management challenges associated with raising her three children, she also discussed the role of the Home Office in creating stress that curtailed her activities.

“We go through maybe like a lot of stress with the Home Office and stuff and I end up not prioritising because of that, because I’m trying to focus on that and then when I start focussing on Home Office issues everything else just falls to the side.”

For Mufaro (f, 40-49, Zimbabwe, asylum seeker), the process had sapped her energy to such an extent that she did not feel she could do much else.

³³ In England this has been called into question with charging being introduced for certain categories of migrants

“Because, yeah, it’s like all the time I will be tired, I’ll just be feeling, now I was sleeping but I don’t wake, I don’t do anything. I’ll just eat, bath, then go wherever I want to go but I was just too tired, like I’ve worked so, so much, but I don’t work.”

8.1.2 Uncertainty

One problematic aspect of the asylum system is the perpetual uncertainty to which asylum seekers are subject. There is already considerable evidence to show that this has a profound impact on the mental health of asylum seekers (Bradby et al 2015:10; Carswell et al 2011:108), but participant narratives suggested that it extends considerably further.

While waiting for a response to their asylum claim, asylum seekers were kept in perpetual limbo. They were unable to develop strong ties, or think seriously about a future in any one place, since they did not know if or when their asylum claim would be rejected and whether they would suddenly be returned to the place they fled from. In one of the Ketso sessions, when asked what impacts on health, a participant spoke first of all about the anxiety caused by an uncertain asylum status *“It’s very difficult because you are not settled, you don’t know what is going to be for tomorrow”*. For this individual, settled status was a key factor influencing health. Stewart referred to this period of limbo as one in which asylum seekers have a ‘suspended identity’, entirely at the will of state power (Stewart 2005:505).

Several more participants described this state of limbo, making clear its deleterious consequences. Elizabeth (f, 40-49, Zimbabwe, asylum seeker), for example had been in the UK for 13 years, unable to settle, seek employment, or see her children who remained in Zimbabwe. Even after this time she did not know if her asylum claim would be successful.

“Up to now, like 13 years doing nothing, just sitting without my children.”

Although Asmeret (f, 30-39, Eritrea, asylum seeker) had been in the country for a much shorter length of time, her anxiety was similar and until she received news of her status she could not relax.

“Very stressful, and till they know, I’m no relax. Seven months, still I am not comfortable sometimes.”

In addition to the general fear of a rejected asylum status, was the potential that someone might be put in detention or sent for deportation with little warning. Many participants had examples of friends or acquaintances that this had happened to.

“Just last month ago they went to take a family, three kids and the mum, in their house, six o’clock, early in the morning. They are gone. They were [are] in Nigeria now, now they alone (...) you can stay here with rest of your life, one day you just go.”

– Awo (f, 40-49, Ghana, refugee)

In this state of limbo, without an assured status, and with a lack of clarity on when that status would be resolved, many activities were out of reach. Tadesse (m, 40-49, Eritrea, asylum seeker) spoke poignantly of the various things he was unable to do.

“You cannot work full time, you cannot go for education and you cannot benefit the country. So I think this makes it very difficult for me at the moment. I cannot do anything apart from waiting.”

Fikru (m, 30-39, Eritrea, destitute asylum seeker) was struck by what he felt was the arbitrariness of the asylum system. While his claim had been refused, many who arrived from Eritrea at the same time as him had been accepted. He felt this was due to asylum claims not being taken sufficiently seriously. Due to this ‘arbitrary’ decision-making he had spent many years in agonising limbo, whilst others had been able to progress. He felt that any decisions about his future were entirely out of his control.

“They need to take our case seriously, especially referring to politicians and immigration system in this country.”

8.1.3 Dehumanisation and lack of agency

Once an asylum seeker becomes a refugee the truth of their experience and the right to reside in the UK is sanctioned, at least by the UK government if not the public imagination. However, for an asylum seeker the experience of suffering, and along with it the legitimacy of a claim to be in the UK remains in question. Asylum seekers in the UK are therefore automatically suspect, the baseline assumption being that they are lying and attempting to cheat the system. This is discussed in more detail in Section 8.2 with particular reference to the role of the media.

“You see people dying and when we come here and because they say you seek asylum or you are refugees they say ‘no, you are lying. They were not going to kill you.’”

– Awo (f, 40-49, Ghana, refugee)

The casting of asylum seekers as suspect has a problematic implication for health (and other) service use since individuals are likely to be concerned that professionals will automatically distrust them, and they in turn might become wary about who they feel they can trust. Asylum seekers are therefore placed in a space where they are less likely to engage openly with public services and in turn less likely to receive adequate care. Returning to the concept of candidacy, this may cause difficulties at a number of stages. First, individuals may be less likely to identify a service or practice as relevant to them, if they feel they will be judged for seeking it out. Secondly, even if they do get past this stage, presentation and adjudication, where claims to care are asserted and negotiated may be compromised either if individuals feel that they are suspect, or if professionals treat them so. The process of candidacy is relevant not only for healthcare services, but other services as well (including the process of seeking asylum). If candidacy is affected in one area, it is likely that the effect will be felt in other areas too. For example, if one service provider treats an individual as if they are suspect, this may also affect how that individual thinks that others consider them.

“I’m thinking how many people are not able, or maybe afraid to share their problems through lack of trust.”

– Melissa (f, 50-59, Zimbabwe, refugee)

For many of the reasons described above, the asylum process is, therefore, a dehumanising one. Participants discussed how being an asylum seeker led them to internalise a great deal of pain and humiliation that accompanied everyday life.

“It’s only, like you know, the way we grew up and we African - even if you’ve got problems, you are suffering - we don’t stop laughing. That’s how we are. So people, if they see you going up and down, up and down, they think things are ok.”

- Elizabeth (f, 40-49, Zimbabwe, asylum seeker)

For Birhan, a refugee from Eritrea who had been in the UK since he was 18, an accumulation of experiences, both related to going through the asylum system and to being

an ‘other’, led to him feel that he was not considered a human in the UK. While he might have been unsafe in Eritrea, he at least had his humanity.

“I was human even though I was not in a very safe place, but I just feel inhuman at the moment.”

While asylum seekers are awaiting a decision on their claims, they are not allowed to work (<https://www.gov.uk/asylum-support/what-youll-get>), and are therefore forced to be dependent on an extremely small stipend. Many spoke of how unhappy this situation made them, and were humiliated at being unable to work or provide for themselves.

“We don’t want to live in free houses. I’ve told the home office that, I’ve said I don’t want to live in your houses.”

– Priscilla (f, 30-39, Malawi, asylum seeker)

Elizabeth (f, 40-49, Zimbabwe, asylum seeker) spoke of her shame during medical encounters, having to tell professionals that she did not work (because she was not allowed to). She felt that this altered the way that medical professionals would look at her, casting her as someone who was less worthy of care.

“It’s very embarrassing to be honest. Me, if I go to see the doctor and then the doctors says ‘do you work? Do you go to work? I say ‘no’. I feel very, very embarrassed. From there, that person doesn’t have respect with you. They will do whatever they want to do.”

In the same way that mistrust alters the candidacy process, Elizabeth’s feeling that she was being looked down shaped her feelings about engagement. A consideration of the role of power dynamics is central to examining how individuals are made vulnerable by structures (Quesada et al 2011:341). Here the importance of extending analysis of power to the candidacy journey is evident. There is some degree of power dynamic in all medical interactions, but this is heightened when the interaction is with an individual who has little control over any part of their life. Indeed, asylum seekers have been cast as powerless by the UK government, devoid of the rights afforded to a permanent citizen (Stewart 2005:501). In this context the implications of suspicion and mistrust (real and perceived) are clear. Both the ways that health professionals and ASRs behave are altered in this context.

Engagement with preventive health requires an individual to take an active role in their health practices and to consider those health practices as worth engaging with. Asylum

seekers, however, are cast as passive agents, with no control over their futures, and forced into being dependent (Stewart 2005). There is obviously a significant tension between health promotion, which emphasises individual agency, and a legal status that diminishes agency. If candidacy is diminished in a setting where someone is actually ill, the likelihood of them engaging in a non-acute setting is even lower.

“I think the main thing is, like, just to finish this about asylum because people, they are suffering to be honest. Suffering in and out.”

- Elizabeth (f, 40-49, Zimbabwe, asylum seeker)

It is not simply an unfortunate by-product that the asylum system creates suffering for those who are moving through it, but is wholly intended by the UK government. In the 1990s laws were enacted to create a hostile environment for asylum seekers (Tyler 2011:84) and they have been continued by successive governments (Mulvey 2015). This suffering is channelled through the routes mentioned above – barring people from working and thus forcing them to be reliant on support, keeping them in poverty (discussed in Section 8.5), forcing people into a state of limbo, and turning them into suspects. That it is intended for asylum seekers to suffer was not lost on the participants, who spoke of the cruelties meted out by the politicians in general and the Home Office in particular.

In the first Ketso group, a participant explicitly referred to government policy when discussing what she would like to see changed to improve refugee and asylum seeker health. Referring to what had been written on her Ketso leaf she noted:

“This one is about Home Office for treating asylum seekers better and also stop harassing them (...) most of them are sick because of the harassment.”

Elizabeth (f, 40-49, Zimbabwe, asylum seeker) succinctly summed up the assaults on her personhood as a result of her status as an asylum seeker.

“They prefer to look after dogs, animals, very well than people. We are not asking them to give us money, we are asking them to give us status so we can look after ourselves.”

In their study of structural vulnerability for hepatitis C risk amongst sex workers and injecting drug users, Rhodes et al suggest that ‘political processes of everyday violence cross over from public space to traumatize personal space and then cross back as collective

experience' (Kleinman 1991 *in* Rhodes et al 2011:213). A similar process can be identified in the case of asylum seekers in the UK. The physical position in which they are put as a result of UK Government policies shapes not only what they have the capacity to do, but also how they view themselves, how others view them, and how they perceive that others view them. Both individually and collectively this has the effect of not only challenging health and wellbeing but shaping the extent to which they are willing and/or able to seek out and advocate for care.

8.1.4 Intersection with place

On arrival in the UK, asylum seekers are dispersed to one of a number of cities in the UK, with no say about where this is aside from in exceptional circumstances (Home Office 2017) They are subsequently housed in accommodation provided by a housing provider. The locations in which asylum seekers reside have the potential to either confer vulnerability or act as a protective factor.

Among public health professionals there was a strong conviction that the context for refugees and asylum seekers was more positive in Scotland than in England. Indeed, a number of the public health practitioners suggested that they were following a different path in Glasgow. As discussed in the introduction, there are significant differences in policy between Scotland and England, with integration processes starting from the moment one arrives in Glasgow as an asylum seeker (Scottish Government 2017). There was also a suggestion that practitioners felt a sense of moral duty towards refugees and asylum seekers, particularly those who are destitute though this would be the case for many in England too.

“I think because it’s morally... like there’s this moral obligation. I remember one of the practitioners saying that we have a moral duty to these people [destitute asylum seekers] and I think a lot of them would see them because there’s just kind of a moral side to it.”

– Janine, Public health practitioner

It has been suggested that the policies and underlying attitude of a receiving environment has an impact on migrant health and wellbeing (Becares et al 2012; Marrow 2012), and a review of the impact of immigration policies on health across the US noted that policy differences between cities made a tangible difference (Martinez et al 2015:965). As described in Chapter Seven, the social support afforded to ASRs in Glasgow made a

positive impact on wellbeing, and it is possible that the policy context in Scotland acts as a protective factor in this way, establishing a context in which ASRs are considered to be deserving of care. Marrow notes a similar situation in San Francisco, where positive policies at the city level created an environment in which undocumented migrants were legitimised (Marrow 2012: 846). However, Scotland has little control over the details of dispersal policy or the places in which ASRs reside, and this makes asylum seekers vulnerable.

Asylum seekers with no right to earn money are reliant on Home Office sponsored housing with no say about where it is they are housed. The homes the asylum seeker participants were placed in varied significantly, and accordingly these participants expressed varying views on the conditions of their housing. It was the professional participants, however, who expressed the most concern about asylum seeker housing stock. Until recently, all arriving asylum seekers were housed in the (now demolished) Red Road flats³⁴ in North East Glasgow. However, with asylum accommodation having been privatised, they are now dispersed throughout the city. In terms of access to healthcare this has had three impacts all of which serve to make asylum seekers more vulnerable. The first was that it is much more difficult to get asylum seekers into the healthcare system since it is harder for health services to track them down and new housing providers do not appear to be playing their part. *“Although the service is here to do it, we just aren’t getting people through the door to do as well, so that’s been a big problem of late (...) we blame the accommodation provider, because part of their contract is to provide access to healthcare”* – Ben, primary care nurse. The second consequence was that GP surgeries with little to no experience of treating asylum seeker patients, many of which were already in deprived and overstretched areas, now had increasing numbers of asylum seekers registered. Similarly, the areas served by Glasgow’s integration networks were no longer the areas in which the majority of asylum seekers lived.

“As the population shifting and the big housing stock is no longer there and people are dispersed, integration networks haven’t quite caught up with that you can’t just work in one area, you have to seek out and look to see where your population is.”

-Laura, public health professional

³⁴ See footnote p.162

Lastly, there was concern expressed on the part of professionals that such policies might contribute to isolating asylum seekers who were now dispersed across the city rather than in one location. This sentiment was corroborated by Priscilla who missed the camaraderie of the Red Road Flats.

“All my immediate neighbours were like either asylum seekers or refugees. So you can like, you have got something in common you know, yeah. It’s not like that here because you are kind of like Scotland here first.”

Public health and primary care services were essentially powerless in the face of the constraints placed by the new housing contract and were having to try to find the best ways to deal with a situation they considered far from ideal. This issue brings into focus the tensions between UK and Scottish policy as regards health and immigration. It also demonstrates how policy at the macro-level, shapes the operating conditions in which care is provided to ASRs. This, in turn, filters down to influence the care that is offered. While there is a good degree of commitment on the part of public health providers to improve access to healthcare for asylum seekers, they are forced to work within the boundaries of immigration policies which are decided at a UK-wide level.

8.1.5 The health impacts of destitution

Section 8.1 has explored the impact of the immigration system, and the status of being an asylum seeker on health and wellbeing. The individuals I interviewed existed on a continuum from destitute asylum seeker to refugee and the extent of their vulnerability was influenced by where they were on this continuum. For those individuals who received a negative asylum decision, life became significantly more precarious, with the risk of destitution, detention or deportation far greater. Fikru had arrived in the UK at the same time as many other Eritreans who were granted refugee status. He however, was not, as a result of what he considered to be an arbitrary decision.

“I am a failed asylum seeker, that’s what they call me (...) in the failed asylum category they don’t care if you have a house or support. You’re vulnerable for crime at any time, you’ve got to do some crime to survive, some of us, we have dependents, so we need to help our family back home, so we have to break the law, get a job, and if you get caught in this country your criminal history will be kept and you will never get a chance to be granted. So everything is, it’s not easy, it’s very, very hard, everyday you see the experiences, wherever you go you get humiliated often and there’s nothing you can do but people treat you as a criminal.”

– Fikru (m, 30-39, Eritrea, asylum seeker)

Destitution put individuals in extremely vulnerable positions as regards their capacity to keep healthy or access care. Audrey (f, 60+, Zimbabwe, asylum seeker), whose story was also referenced in Chapter Five, had been destitute until starting a fresh asylum claim. In the time that she was destitute was diagnosed with both depression and type II diabetes.

“I was so depressed and then I got for depression tablets because of the living, the cost of living, it was very hard to me. I was a destitute for a long time. I think for three months, three to four months I was just two days I am sleeping on another place. I said ‘I just want you for two days’ another one for a week, another one for... it was so stressing me and I was depressed so I ended up going to the hospital, they gave me depression tablets.”

“The time I came here, you know, through friends they say ‘oh you are losing, you can have this chocolate’. I was eating chocolates. I think that’s where I get the diabetes. And I was starting putting sugar, little bit here, little bit until I was three teaspoons in a cup of tea. It was too much. I started to like the sweetness, I didn’t know the sweetness was going to kill me.”

These two narratives demonstrate how the structure of the asylum system places individuals in a position of vulnerability for both poor physical and mental health. Audrey’s depression came about as the result of a very concrete situation and one of her coping mechanisms – changes in her diet – had potentially impacted on her health profoundly.

As discussed in Chapter Seven, accessing healthcare while destitute is a risky activity. While Scotland maintains control over healthcare and thus who healthcare is provided to (which includes destitute asylum seekers) the UK Home Office is increasingly attempting to co-opt healthcare professionals into acting as border guards, encouraging them to divulge patients’ immigration statuses to the UK border agency (BMJ 2015; doctorsoftheworld.org.uk). Such actions place individuals in highly vulnerable positions as a result of their legal status and indeed there is evidence that pregnant women are already avoiding care due to fears over their legal status being disclosed (doctorsoftheworld.org.uk³⁵). Even if Scottish healthcare professionals are not engaging in this practice it is likely to have a negative impact.

³⁵ Full reference: <https://www.doctorsoftheworld.org.uk/news/pregnant-women-should-never-be-frightened-away-from-antenatal-care>

8.2 The political/ media context around asylum and migration

In addition to the ways in which legal status impacted on refugee and asylum seeker health practices, access and engagement, the broader political and media context played a role as well, particularly in terms of the ways that participants perceived of themselves and the structures around them. Fieldwork interviews took place over a particularly turbulent period of time in relation to asylum and migration issues. This included the 2015 UK general election in which migration became a topic of significant debate between the major political parties and the refugee crisis, largely fuelled by the war in Syria, that dominated the news in the summer of 2015. Because of this, the link between migration and politics was perhaps even more prominent than usual.

“Syria at the moment, the Syrians are in the news and so everyone wants to jump on that bandwagon.”

– Laura, public health professional

“It has become a big political debate, political issues that you know, some politicians are taking advantage.”

– Azzam (m, 40-49, Ghana, asylum seeker)

Although participants were often positive about the spirit in which they had been received in Glasgow, when asked about how they felt migrants were viewed by politicians, the media, or general population, their feelings changed considerably.

“Maybe they feel that ‘this is our country, you people are coming, you know, to take our... what’s the word? Things that belong to us and such.’”

– Tadiwa (f, 50-59, Zimbabwe, asylum seeker)

Disquiet about the ways that migrants are portrayed in the media is certainly borne out by the evidence. While it is not always clear whether the catalyst is the media itself, or public opinion to which the media responds, negative rhetoric on migration has been fairly consistent³⁶ (Greenslade 2005; Philo et al 2013). Additionally, there was a sense that politicians and the media collaborated to colour public opinion and exploit migration for political gain. Many participants felt that politicians and the media were directly

³⁶ See section 1.1 for more detail on public and media attitudes towards migration

responsible for propagating unhelpful myths about asylum seekers. Although it is impossible to identify a direct causal relationship between political rhetoric and public opinion, and the influence likely moves in both directions, desire to reduce migration is clear. Even in Scotland where public opinion is more favourable than the rest of the UK, 58% of the population wishes to see rates of migration reduced (Migration Observatory 2014:2).

“I think the politicians seem to be responsible at the moment, like UKIP, yeah (...) they have got to please the public because they want to be voted into power.”

– Tadiwa (f, 50-59, Zimbabwe, asylum seeker)

“The media has tried to empower racism back again (...) and there is always something in the media about migrants this, migrants that.”

– Thandi (f, 30-39, Zambia, asylum seeker)

“Public perceptions flick along with the media as well.”

– Nicholas, public health professional

ASRs were concerned about the motives attributed to migrants, for example that they were coming the UK so as to be able to claim benefits, and in the case of refugees, that they left by choice rather than out of necessity.

“What people think is that migrants come to take the benefits and they come to take the jobs and I think it’s wrong.”

– Priscilla (f, 30-39, Malawi, asylum seeker)

“They always see migrants, oh you are moving from here to there or invading to something but refugees are the same thing, but it’s very straightforward, no one likes to move from their country.”

- Birhan (m, 20-29, Eritrea, refugee)

In the same way that the asylum process seeks to exclude those who go through it, prevailing narratives about asylum and migration play a similar role, suggesting to refugees and asylum seekers that they are not trusted and not welcome. They also contribute to a climate in which claims for care are delegitimised, even if individuals are technically entitled to that care (Larchanché 2012:859). The result of this, as well as being

detrimental to wellbeing more generally, is that individuals come to expect that they will be treated in a particular manner, reflective of the position that they occupy in society. Fikru, a destitute asylum seeker had been frustrated by a long wait for a hospital referral. When I asked him why he felt this had happened, he responded that it was due to his not being important: *“Maybe I’m not important, I don’t know. Why do they have to spend so much money on me?”*

8.3 Racism, discrimination, and ‘othering’

Racism and ‘othering’ directed towards the refugee and asylum seeker participants was discussed in almost every interview in relation to its impact on health and wellbeing and also more broadly. While it was by no means the only way through which participants defined their relationships with individuals from Scotland, participants did discuss a pervading sense of ‘otherness’ that coloured many of their experiences. Participants were both black and audibly ‘foreign’ and thus were particularly marked out as different.

“I wouldn’t say racism. There is that kind of fear when you meet them, they feel threatened. I don’t know where that comes from.”

– Melissa (f, 50-59, Zimbabwe, refugee)

In terms of health, participants demonstrated how experiences of racism had a negative effect in two distinct ways. The first was through receiving what was perceived to be poorer care, and the second was through insults to personhood that negatively affected wellbeing and willingness to engage. Additionally, negative experiences accumulated, with one episode where participants felt they had been mistreated having a knock on effect and influencing future engagements. Racism/ discrimination was therefore an important factor shaping vulnerability for ASRs.

Racial discrimination cannot be understood in isolation from what many participants will have faced either as current or former asylum seekers – a significant amount of suspicion and mistrust about the truth of their claims. Experiences of racism and anti-migration sentiment are closely bound together in this way. Many participants already assumed they would not be trusted, due to their identities as asylum seekers, or former asylum seekers.

8.3.1 Perceptions of racism in Scotland

“Scotland, because it came, you know, from behind, to welcome foreigners, it has taken them that time to you know, really embrace us.”

– Brenda (f, 50-59, Malawi, asylum seeker)

Virruel-Fuentes et al note the importance of examining the impact of structural racism as well as individual discrimination (Virruel-Fuentes et al 2012:2102). Both types were present in the ASRs narratives, although there was no consensus amongst the participants as to whether racism was an individual behaviour or embedded within institutions and structure. For Awo, racism was conceptualised as a trait of individuals, a fact of life, and as much of a concern in Glasgow as anywhere else:

“Every place you meet a challenge, you meet a racist, but for me I would say racists is everywhere. Back home. Here”.

– Awo (f, 40-49, Ghana, refugee)

For others, however, racism was far more pervasive and its implications more profound. This was expressed particularly clearly through concerns about the extent to which the police could be trusted. A participant in the first Ketso session noted that while racist incidents occurred, refugees and asylum seekers felt unsafe reporting them lest the police turn on them instead:

“Fear of victimisation I don’t know whether you could concur with me why the police, people, I mean most of the ethnic minorities or asylum seekers don’t want to report like crime and I put here clearly that people keep secret of racism, people don’t like to talk about it and we are racially, what do I mean to, people can confront you in a racial manner but you do not really want to report and it’s another big problem that I’ve seen is the moment you report to the police, the police comes in they start investigating you know [over talking] so whether people get racially or they are attacked racially they don’t want to talk.”

– KETSO 1 participant

This view was echoed by a public health professional also.

“let’s say you have got an issue, something that needs police intervention, maybe you phone, it’s clear that you are not Scottish and maybe they might take time, longer for example (...) and people were saying see here, because we’re Africans see.”

– Nicholas, public health professional

Here the intersection of race and asylum status is particularly clear in terms of placing participants in a space of vulnerability. Not only may individuals be victims of racist incidents, but they are then unable to report those incidents due to concerns that the police themselves are racist and either they will not be believed or, even more worryingly, their status as asylum seekers will be jeopardised if the police instead turn on them. Page-Reeves et al, in their study of Latino migrants' experiences of diabetes prevention, suggest that this fear is a form of structural violence. They describe how the fear that engagement will have negative consequences leads migrants to stay away from services, including health services and preventive programmes (Page-Reeves et al 2013b). This in turn puts them at increased risk of preventable disease. This is also another example of the candidacy process for one service having the potential to affect the candidacy process for another.

8.3.2 Implications for wellbeing

In discussing wellbeing, and what influenced health, the impact of racism and discrimination was mentioned regularly. The following discussion in the second Ketso group provided such an example. The participants were at the stage of the session where they were discussing the things they had written on their Ketso leaves that negatively affected their health in Glasgow.

Participant 1: [referring to what he had written on his Ketso leaf]: criticism and ignorance

Participant 2: Does it affect your health?

Participant 1: Very much so, I mean this discrimination you know? Even the services, you know? Even if you... just, you know things that you can get, you know, easy, but because maybe you are black you are treated in a certain way, you don't get certain things or those tell you. You know when I was first in Glasgow they could even give me wrong directions, so you would think you're asking for Tesco and they will tell you it's the other direction you know.

Participants suffered every day 'micro-aggressions', that though subtle had a lasting impact.

“You even go into Boots where as a woman you're just shopping for tiny things a woman needs, you find maybe she doesn't even want to touch your skin to test the product on you.”

– Thandi (f, 30-39, Zambia, asylum seeker)

“You can go into the shop, the person in front of you is paying with a £20 note, but yours, if you are paying, they take a pen and just swipe the money to see if it’s fake or not. It’s very painful.”

– Elizabeth (f, 40-49, Zimbabwe, asylum seeker)

I wouldn't get them because they tend to fear me, they don't trust me, they don't know me, I'm a stranger. I tried to do some cleaning, general cleaning in the houses. I put my adverts at the shops around here. No-one called me to go and clean. There was only, ah, there was only one woman who was so desperate who called me. So when she heard about my voice she said “Oh, are you a coloured?” well, and I said “I'm not a coloured but I am a black African.” She said “Ah, okay. Thank you, bye.”

- Melissa (f, 50-59, Zimbabwe, refugee)

The effect of these and other incidents was that participants felt humiliated. Additionally, their ‘otherness’ was reinforced. Although, as discussed previously, there are many inclusive community efforts in Glasgow, the notion that black refugees and asylum seekers were not entirely welcome prevailed. *“We are strangers here and you have your own lifestyle so we are barging into your way of life”* – Brenda (f, 50-59, Malawi, asylum seeker). Krieger, in her work on the embodiment of inequality, developed the notion of ‘biological expressions of discrimination’ (Krieger 1999: 331), whereby experiences of racial discrimination are embodied and expressed biologically in a way that contributes to ethnic disparities in health outcomes (ibid). One of the ways in which she suggests discrimination can affect health is through ‘socially inflicted trauma’ (ibid:332), similar to what the ASR participants described above. Though its effects may be profound, it is difficult to quantify the exact impact of this form of racism since it is so pervasive (Liburd et al 2005:18).

Although there has been limited study of the links between racial discrimination and health outcomes for chronic diseases in the UK (Karlsen & Nazroo 2002:18), there is evidence from the US to suggest it does have an effect, particularly, but not solely, in terms of self rated health (Ayotte et al 2012; Gee & Ford 2011; Krieger 1990). Going further, Lukachko determined that there was a potential link between structural racism and risk of myocardial infarction.

8.3.3 Implications for service use

Discrimination can affect health through inadequate service provision (Krieger 1999:332; Liburd et al 2005:18). A number of the ASR participants described experiences of consultations with health professionals where they felt that they had not been taken sufficiently seriously. While some attributed this to asylum seekers being considered unimportant (see Section 8.2) others considered it a question of race and foreignness, that they were less trusted because they were black and not from the UK.

Elizabeth (f, 40-49, Zimbabwe, asylum seeker) spoke of going to A&E following a road accident, to be told by the doctors, who didn't believe she was in pain "*your story is not working out*". Elizabeth believed her status as a 'foreigner' meant that professionals felt able to take advantage of her.

“Because some of the doctors and the nurses, they get like ‘these people, they are foreigners – they don’t know their rights.’ That’s the problem, again. We know our rights, but what can you do?”

In this case, discrimination had a profound impact on Elizabeth's candidacy. Not only had she been refused the care she had been seeking, but it had left her feeling that she had no agency to assert herself.

Mercy (f, 40-49, South Africa, refugee), who suffered from serious depression, had a troubling healthcare experience when she was removed from her GP surgery list for missing an appointment. Again, she attributed the fact of her being African to the surgery staff's unwillingness to be understanding about what had happened.

“So when this one said to me they can't take me anymore because I didn't come for appointment, they didn't understand my situation, like some of them you see when is African people they have, they have that attitude, you know? If like, like, if we can (...) treat people like equally, and the dignity and respect, life would be easier. You know?”

Such perceptions have concerning implications for future engagement, not just with the specific services that participants felt had not taken them seriously, but also with services more generally, since participants consider these attitudes to be part of a general trend, rather than isolated experiences.

“This thing for racism is secret. Someone will pretend as if the person that is not a racist, but the person is a racist.”

– Elizabeth (f, 40-49, Zimbabwe, asylum seeker)

Indeed, despite considering Glasgow to be an increasingly tolerant city, it was acknowledged by public health professionals that the memory of years of discrimination impacts negatively on individuals' willingness to engage with services or the Glasgow community.

“People find it hard to settle into because a lot of the time it's some of it is the perception of theirs that people don't welcome them and some of it is true as well because they do experience racism and you know other discriminations and it doesn't encourage them to mix with the community.”

– Marion, public health professional

After Elizabeth's experience at the hospital she said that she would not seek out medical care at a hospital again, even if she felt very ill, as she was so unhappy at how she had been treated. She no longer identified this particular service as one that would be relevant for her.

“No. Even if I've got, like now, a very painful, like – one time, I couldn't walk, I couldn't do what – and (name) was saying ‘oh my God, what can we do?’ I says ‘I'm not going to call ambulance. I'm not going to do nothing, or just go home’ because it's, you know what they say to me?”

Racism within the NHS has been well documented, particularly in England, with concerns that too little progress has been made in recent years to improve either experiences of care or health outcomes for BME service users (Kline 2014; Salway et al 2016). In particular, efforts to translate equity policies into action and increase the diversity of the workforce have had limited success (ibid).

8.3.4 Being ‘other’ and using space

Perceptions of racial discrimination influenced the ways that ASR participants used their local areas, as well as the city more broadly.

Public transport was considered to be a site in which racism was expressed in particularly overt ways, with unfriendly behaviour on the part of drivers and passengers being attributed to racist attitudes. In similar ways to those described above, these episodes of discriminatory behaviour left participants feeling as if they were not truly part of the city, but powerless to do anything to change this.

“Sometimes it depends with the driver, who is driving, some they are very nice, some they are very rough, there is nothing you can do because I can't drive a bus. I'm an immigrant, I'm asylum seeker, I don't have to complain. My colour, I'm black again, so I can't complain.”

– Audrey (f, 60+, Zimbabwe, asylum seeker)

Ketso 2 participant: “Public transport there's segregation. If you are the first one to sit, no-one will come and sit with you.”

Anna: Do you think that's...

Ketso 2 participant: It's sort of racism like.

Ketso 2 participant: “And the old people prefer to go standing because they don't want to sit with you. That is very common. But myself I like it because I take my bag and put it there.”

Concerns of racial discrimination also led some participants to worry about being conspicuous in their local area. Mufaro (f, 40-49, Zimbabwe, asylum seeker) declined an offer to do a walking interview around her neighbourhood in large part because she was concerned about what other residents might think about a black woman walking around me, a white woman and was wary of the unnecessary attention it might draw.

“Yeah, it won't be good. Maybe they will be thinking that this foreigner one is doing something again, so which won't be nice.”

Stewart, in her work on the vulnerability of asylum seekers, notes that vulnerability has a spatial aspect to it (Stewart 2005:507). ASRs may feel vulnerable in public spaces not only because they are ‘othered’, but also because they lack the social connections that could mitigate that othering (ibid:508). Barriers to the use of neighbourhood spaces have implications in terms of participants’ abilities to engage in health practices and also in terms of where services are directed. This is further discussed in Section 8.5 which focuses on the neighbourhood environment.

8.4 Access to financial resources

Fleischman et al note that it is important to consider not just those structural determinants that are specific to being a migrant, but also those that are made worse by it (Fleischman et al 2015: 95). Constrained access to financial resources is certainly not particular to the experiences of refugees and asylum seekers, and there is considerable research and data, including in Glasgow, that links low socioeconomic status to poor health outcomes (*e.g.*,

Alexander et al 2009; Marmot 2005). Much of the detail here is therefore of relevance to other groups also. Poverty is, however, a defining feature of the lives of asylum seekers and many refugees. Although not all participants struggled financially, the vast majority of them did. Asylum seeker participants were living in extreme poverty because they were forced to do so by an asylum system that bars them from working and provides an extremely small living allowance of £36.95 a week (gov.uk/asylum support)³⁷. For many participants, their economic situation was directly tied to their asylum status, for others it was tied to the difficulties of transitioning to the status of refugee.

The negative effects of poverty on the ability to prioritise health and wellbeing were writ large across the interviews and focus groups. Many ASR participants noted “*financial circumstances*” on their Ketso leaves when asked what was negative for their health and discussing this in greater detail in interviews. Participants were explicit about the role that poverty played in constraining their autonomy and linked this directly to their experiences as ASRs.

“Asylum budget extremely hard to stretch. If you’re getting like £35 a week and you need to buy a bus ticket for £17.”

– Elizabeth (f, 40-49, Zimbabwe, asylum seeker)

While both the asylum seekers and refugee participants experienced a degree of poverty, the situation was considerably more extreme for those participants who were, or had been, destitute. As described in Section 8.1.5 the combination of extreme poverty and anxiety associated with destitution put individuals in highly precarious situations and had an extremely detrimental impact on health.

While the ASR participants felt that their poverty would be alleviated by being allowed to work, “*We are not asking them to give us money, we are asking them to give us status so we can look after ourselves*” (Elizabeth, f, 40-49, Zimbabwe, asylum seeker), refugee status did not offer an immediate solution. The effort to find a job and therefore a secure income, while a smooth process for some, was extremely difficult for others. Refugees are often left with no support on receipt of refugee status, as there is a gap between asylum support being cut off and the provision of regular benefits (Basedow & Doyle 2016) and required to find work in a short space of time. When the requirement to find a job was

³⁷ See list of definitions for more detail on asylum seeker entitlements

hindered either by health issues, or language barriers the result could be extremely stressful, making it very difficult for individuals to find their way to a secure income.

“The job centre they were, they were telling me to go to college to do that course to earn, but I can't, because, the depression is still in my body, you know? Sometimes I put something there, the next thing I don't know. Was when I was moving with this house, I came in this house like it was empty, nothing. It was nothing, no floor, no carpet, nothing. No bed. Nothing. You know that time waiting for that, what they call it? When you waiting for Scottish Welfare to give you bed, stuff like that, it would be fifteen days in the house. So at that time I got not even check the job that the job centre website. And then they sanctioned me. So they didn't understand the way I was living there is a personal health, asthma like me, because it was the dust, and that dust was affecting me when I came here. So everything was too much for me and then my depression got back again. Because they didn't understand my situation.”

- Mercy (f, 40-49, South Africa, refugee)

Osman (m, 30-39, Eritrea, refugee), who faced the added barrier of limited English considered the pressure to find a job quickly on receipt of refugee status, unfair or perhaps unrealistic, since it was close to impossible with the level of English that many refugees have:

“The job centre here is make big problem of the people about working, ask them to work, but the people doesn't speak English, so not easy to find work.”

8.4.1 Impact of financial constraints on health practices

As discussed in detail in Chapter Six, most participants emphasised the importance of individual health practices, particularly around diet and exercise, in the maintenance of a healthy life. However, while these practices were considered to be a matter of individual choice in theory, they were recognised to require a level of financial (and other) resources that many participants did not possess. Poverty was considered to impact significantly on individuals' autonomy, so while the participants might have been aware of the resources technically available to them, they were very clear about the reasons they were unable to engage.

“You know our monies, we are not working. Our monies not let us do all something.”

– Asmeret (f, 30-39, Eritrea, asylum seeker)

“There is availability of you know, things you can do in the area. Yeah, except the fact that, you know, like some of us, we cannot afford.”

– Tadiwa (f, 50-59, Zimbabwe, asylum seeker)

“Yeah when I moved here, yes. That’s when I realised you can eat whatever you want as long as you can afford.”

- Melissa (f, 50-59, Zimbabwe, refugee)

It was acknowledged that ‘healthy’ food was more expensive than ‘unhealthy’ food and so if one was under financial constraints, healthier choices became prohibitive even if they were desired.

"I don't know what I'm eating because I can't afford what I need to eat so it's actually, you know, ups and downs. Two or three days in a week or in two weeks or in a month you would eat healthy because you'll be supported by somebody else, but again you won't make it, like cooking for one to lead a healthy lifestyle that you want and how you can manage your health. You wouldn't manage it because of all these restrictions."

- Thandi (f, 30-39, Zambia, asylum seeker)

“There are times like they are saying times are hard you know people want to eat healthy but there are days when you don’t have anything, you don’t have money so the better option is to buy it, the £1 pizza or and by so doing you are creating chances you know of diseases then so.”

– Joseph (m, 40-49, Zimbabwe, refugee)

Both Joseph and Thandi underscored the point that there was no lack of desire to buy healthy food, but that it was simply unrealistic given the constraints that many lived under.

Not only did many participants not have the financial resources to buy the food of their choice in the supermarket, but they were constrained further by having to rely on food banks to supplement their purchases.

“So the food-wise is very tough these days, because of that I will manage, say, I will go to food bank and see what food I can get”

– Awo (f, 40-49, Ghana, refugee)

As Priscilla (f, 30-39, Malawi, asylum seeker) noted, food banks themselves were also constrained due to increasing demand.

“Some places like there is one good one in Anniesland they will look at your financial position, your immigration status and they will tell you how many days you can go and I used to go like twice a month now they have changed it to once a month, I think they are also finding it hard so they can't have everyone like go that often so now they are reducing how many times you can go to those food banks so I guess they are feeling the pressure as well so.”

Exercise, similarly, while important for maintaining good health was considered to be something for others to engage in.

“Exercise is also important but we just don't have the availability of funds for that.”

– Tadiwa (f, 50-59, Zimbabwe, asylum seeker)

“Not many of us have enough money to eat and go for gym.”

– K001 participant

It is noteworthy that although a number of the participants walked reasonably regularly, exercise tended to be conceptualised as activities that required payment, such as the gym or swimming which were mostly out of reach. This was further emphasised by the fact that it was not only one's ability to engage in activities that was constrained by income, but also the ability to travel to those activities. Therefore, even free activities could be prohibitive given the resources they require to engage.

“You can come and attend that one, but it means you have to have bus money.”

– Tadiwa (f, 50-59, Zimbabwe, asylum seeker)

“I don't get the train to go – it's expensive.” – Ketso 2 participant

Many ASR participants were clear that the ways in which they lived were not optimal from a biomedical health perspective. This was not, however, something that they considered to be in their control. Returning to Bourgeois et al's (2011) notion of structural vulnerability it is possible to see that the structural constraint of poverty is one way through which refugees and asylum seekers are made vulnerable to poorer health outcomes. It was not that participants did not identify themselves as candidates for particular health practices (although as mentioned in Chapter Six these had not necessarily been cultural norms previously), but simply that candidacy was irrelevant in practice due to the many barriers along the pathway to achieving it.

8.4.2 Professional responses

“There’s huge amounts of deprivation to tackle in addition to the different needs of different ethnic minority groups so I think that does make it more complicated.”

– Adrian, public health professional

Glasgow is a city with a long history of economic inequality (Alexander et al 2009), with many ‘indigenous’ residents at the lower end of the socioeconomic scale living with poor health. While the ASR participants didn’t describe themselves in the same terms as others living in poverty in Glasgow (and in fact often described themselves in contrast to these individuals) the professionals I spoke with considered poverty a shared experience of native white Glaswegians and more recent migrants, refugees and asylum seekers.

Much research has criticised the medical profession for giving primacy to cultural barriers over structural ones (*e.g.*, Castañeda et al 2015). Although the public health and primary care participants did speak about culture, they were also clear about the financial difficulties faced by asylum seekers and many refugees. This is perhaps understandable given that poverty and inequality are already such pervasive features in Glasgow.

Paul, a GP, worked in one of the most deprived areas of Glasgow in a surgery that saw increasing numbers of refugees and asylum seekers. He suggested that this was less of a challenge in his surgery than it might be in others, because his ‘normal’ was already very deprived.

“I suppose it depends on what’s normal for you because us in X, the most deprived area or the most deprived practice in Scotland for us it’s normal to have a 45, 50 year old patient with four, five, six co-morbidities whereas that might not be normal in Hyndland [an affluent area] or wherever else you go to so there is nothing that I can see that is out of the ordinary for the population that we are in but it might be out of the ordinary for Scotland.”

Although he still discussed differences in cultural norms about use of healthcare, this was framed alongside an awareness of severe deprivation.

Although aware of its limits, public health professionals were keen to stress efforts to lift the barriers caused by financial poverty, expressing awareness that financial barriers extended beyond not being able to afford an exercise class. It is noteworthy that many of

the public health professionals with whom I spoke have spent time engaged with refugee and asylum seeker organisations and so have been able to consider a wide range of issues.

“Particularly when people are destitute and have had leave to remain refused, you know they don’t have leave to remain so they are absolutely destitute so those are big big issues for people and they are very, very much at the margins, we’ve got food banks, locally we have got a money advice service that NHS fund.”

– Laura, public health professional

“Physical activity and access to free physical activity or reduced cost, that has been a huge issue. But not only just access, even being able to get the equipment you know we have managed to negotiate at times free swimming but you know it’s a cost of how do you afford a swimming costume to go swimming you know, how can you afford the transport costs to actually get to some of these activities.”

– Mary Anne, public health professional

Mebrahtu (m, 30-39, Eritrea, asylum seeker), however, felt very strongly that professionals still did not understand this aspect of his life and stressed how difficult it was even to ring to book an appointment if you couldn’t afford any credit for your phone:

“To me it seems to be like the health professionals they don’t understand asylum seeker and refugees; they don’t understand our issues (...) you are asked to phone to arrange an appointment (...) you don’t have enough credit.”

8.5 The neighbourhood environment

The neighbourhoods and environments in which participants lived, and the relationships that participants had to those environments played a role in influencing both wellbeing and engagement with health practices. While those participants with children spent more time in and had a greater sense of connection to their neighbourhoods than those who did not, there was a general sense that participants had fairly tenuous links to their local areas. This was partly logistical – many had had to move quite regularly, but there was also an emotional element – they did not feel particularly connected to either the people or the places in which they resided. I conducted walking interviews with three interview participants. For the others this was not practical for a variety of reasons. Some I did not meet at their home; some had caring responsibilities that meant they could not go out. Others felt sufficiently uncomfortable in, or disconnected with, their neighbourhoods that

taking a walk around their immediate locale would have indicated little about the geographies of their lives.

The neighbourhoods that participants lived in varied considerably, and alongside that variation, feelings towards those neighbourhoods. One aspect that many commented on however (generally positively) was the quietness of their local area, often in comparison to what they had experienced in other parts of Glasgow.

“It’s a good residential area; it’s very quiet. It’s very different compared to [list of other areas] the street where I am living is very quiet, it’s not been very... it’s even rare that you see a lot of police cars.”

– Thandi (f, 30-39, Zambia, asylum seeker)

“I think over the years you know this area used to be a bad, bad area because of the high flats there was a lot of drugs, a lot of you know, bad things happening associated with drinking and you know drugs, but now since the Red Road flats are almost gone the area has become quiet so it’s now filled with friendly, there is not a lot of cases of you know drunken people so it’s now a pleasant area to stay.”

- Joseph (m, 40-49, Zimbabwe, refugee)

On the other side, the negative aspect of living in a quiet area was that people did not necessarily feel a sense of community. Brenda, an asylum seeker from Malawi who appreciated how the hilly contours of Glasgow reminded her of her home spoke about the neighbourhood with some detachment.

“I’ve not gone out a lot to say to meet people but generally when we meet them on the bus I feel it’s a nice place to live.”

Elizabeth (f, 40-49, Zimbabwe, asylum seeker) expressed a similar sentiment – she didn’t disturb the people living near her, and they didn’t disturb her.

“The neighbourhood, they’re good. Though I don’t speak to them, but I don’t have problem with them.”

8.5.1 Neighbourhood facilities

Although many participants made limited use of their local area, proximity to useful resources was still important, influencing how easy cheap and healthy food was to obtain, whether there were accessible exercise facilities, and how quickly one could access other

areas of the city. Depending on the neighbourhoods that participants lived in, affordable shops were more or less easily accessible. Hazel's experience contrasted sharply with Priscilla's for example:

“If you go down X road there is transport, there's shops there. There's Tesco there and Asda is just a few minutes away from here. I can walk to there and it's Farm Foods down there. And so I think... yes. Everything is just around us. And the hospitals...” – Hazel (f, 30-39, Zimbabwe, refugee)

“We don't have not many facilities; I can't do most of my shopping around here.”

– Priscilla (f, 30-39, Malawi, asylum seeker)

The ease with which one can obtain affordable, healthy food is one factor that has a direct impact on individuals' capacity to engage in healthy eating practices. A lack of access to affordable food was thus an example of where structure could impact on the candidacy process. Navigation and permeability are the stages of the candidacy process that relate to how easy it is to seek out a service. In this case, where the 'service' was access to healthy food, the level of permeability depended on how easily they could get to a shop and, referring back to Section 8.4, the cost of food once they were there.

8.5.2 Concerns around anti-social behaviour

Various negative feelings were expressed about the neighbourhoods that participants lived in, and the other people who lived in them. These neighbourhoods tended to be in the more deprived areas of Glasgow. In particular concerns were raised around antisocial behaviour, such as noise, fighting, and drug and alcohol consumption:

“They go outside on the stairs, start drinking, smoking, making noise.”

– Elizabeth (f, 40-49, Zimbabwe, asylum seeker)

“And when the people, they get drunk, they can come back to your flat and make noise and they fight every time. They run after each other fighting when they are not drunk.”

– Esther (f, 60+, Zimbabwe, asylum seeker)

Participants were clear to draw distinctions between these practices and their own lifestyles. Marion, a public health professional noted that one reason for a lack of

integration is asylum seekers being housed in areas that were already suffering from significant social deprivation.

“Inequalities they are then obviously there are a lot of reasons for people for not to integrate or poor knowledge or you know so it is definitely and we know that BME communities or asylum seekers are those communities who experience poverty, you know there is definitely, there is low employment in these communities and the mental health issues are quite high as well so all these compounded impact and where they live.”

8.5.3 Participant geographies

A number of participants felt uncomfortable spending time outside and chose to moderate their activities accordingly, only leaving their house to travel to particular destinations (e.g., friends, work, education, community groups) in other parts of the city, and spending limited amounts of time outdoors. This was in part due to the reasons above – concerns around antisocial behaviour – but touched on other concerns as well, namely, that as visible black migrants they might attract too much attention to themselves and cause problems.

“I have seen a lot of alcohol, I mean alcoholics and you know, drug addicts around which is not nice thing to be experiencing (...) Actually I have said to myself, I’m not going to spend time outside, so I mean I’m either in or I’m, you know, away so I don’t stay loitering around, no.”

– Azzam (m, 40-49, Ghana, asylum seeker)

“Sometimes, we again, because we are migrants, we do create some noise with other people, but me, I don’t have that time. I’ll go to the city and just come straight away my house.”

– Elizabeth (f, 40-49, Zimbabwe, asylum seeker)

As described in the section on racism, Mufaro (f, 40-49, Zimbabwe, asylum seeker) who was extremely disparaging about her neighbourhood, felt uncomfortable taking me for a walk around it due to her visibility as a black woman.

“This neighbourhood is the worstest neighbourhood in Glasgow. Even ask anybody, especially this street which I am staying, it’s not good. They are, most of them are drug addicts and they’ll fight and they’ll make noise every time, even in this block.”

Discomfort in, and disconnection with, the local area provides another example of how intersecting structural disadvantages place refugee and asylum seeker participants in a space where they are at greater risk for poor health and wellbeing. In this case, the challenges of residing in a socioeconomically deprived neighbourhood (relevant also for many ‘indigenous’ Glaswegian residents) – fears around crime and antisocial behaviour were exacerbated by the anxiety of being visibly ‘other’ and therefore a potential target. Local spaces where people might go to exercise, or local organisations where they might develop community bonds were considered off limits to them. Asmeret (f, 30-39, Eritrea, asylum seeker), as described in Chapter Six, felt too uncomfortable in her local area to spend time exercising outdoors.

“If you go out, is maybe difficult, I am scared to disturb people. And still now not doing any exercise. Just some walking for a little bit then come back.”

These reasons together with the fact that participants had connections in other parts of the city meant that the geographies of the participants’ lives did not necessarily match up with their physical geographical location. Many participants lived between their homes, community centres and other friends’ homes, spending limited time in their immediate neighbourhoods.

“Yeah, I wouldn’t say I’ve got a friend, but we just greet each other. But my friends are [in other areas], of my own race, you know.”

-Melissa (f, 50-59, Zimbabwe, refugee)

The mismatch between participant geographies and local geographies has relevance for place based interventions, since if refugees and asylum seekers do not consider what happens in their neighbourhood to be relevant to them, they are unlikely to benefit from interventions that are directed at a particular place. Additionally, a disconnection from the places people live served to reinforce a sense of disconnection from Glasgow more generally. It is possible, however, that a disconnection from the places they live might actually act as a protective factor for some ASRs, given the numerous inequalities associated with some of the more deprived areas in Glasgow. Kearns et al, in their study of migrant health in Glasgow noted that refugees (though not asylum seekers) were less affected than UK-born individuals by living in a deprived area, tending to be healthier than those native Glaswegians living nearby. (Kearns et al 2017: 685).

From the public health angle, there was a concern that place based service provision (e.g., integration networks) did not match up with the places that individuals lived. This was certainly born out in the experiences of the participants, many of whom travelled considerable distances from their homes to attend integration networks.

“For example X integration network says they are working in Y, but we know that’s not happening.”

– Mary Anne (public health professional)

It is impossible to say whether there are many refugees and asylum seekers living in areas without integration networks who were therefore not receiving those services. For those that I interviewed, their experience of Glasgow was not orientated around a local community, but through those organisations, wherever they were, that sought to serve refugees and asylum seekers specifically.

8.6 Conclusion

Moving from the micro- to the macro-level, this chapter has described the various structures that put the ASR participants in a position of vulnerability that affected their wellbeing and diminished their capacity to assert their candidacy for primary and preventive health care. The participants were made vulnerable by the constraints of the asylum system, by media and public attitudes towards asylum seekers, by living in poverty, and by racial discrimination amongst other factors. Some of these factors were directly related to the immigration and asylum system, and some were exacerbated by it, demonstrating clearly the role the asylum system has in shaping health and health outcomes. Importantly, it is not necessarily useful to look at how structures made an impact in isolation. Rather, these structures interacted with and compounded each other to put the participants in specific spaces of vulnerability. Racialised discrimination intersected with negative stereotypes of migrants to place participants in a space where they felt that they were treated as foreign, other, less important and less trustworthy, yet as ASRs they had limited recourse to justice. Similarly, the dehumanising nature of the asylum system intersected with poverty to limit the control ASRs had over their lives, significantly diminishing their ability or desire to engage in health practices.

Having explored perceptions of health and wellbeing, and perceptions of primary care in Chapters Six and Seven, and contextualised them in terms of the structures that shape them

in Chapter Eight, this thesis moves to the final discussion chapter in Chapter Nine. Here I will explore the utility of the theories of candidacy and structural vulnerability for understanding ASR health with particular reference to prevention, discuss the role of the UK asylum system as a determinant of ASR health, and finally reflect on the experiences of conducting research with marginalised communities.

Chapter Nine: Discussion

This thesis has explored the health and healthcare related experiences of asylum seekers and refugees from Sub Saharan Africa living in Glasgow. In particular, I sought to understand perceptions of health and wellbeing, experiences of engagement with primary and preventive healthcare, and what the implications of these perceptions and experiences might be for developing preventive interventions and services for this population. To carry out the research I designed a focused ethnography, drawing on tools from the fields of critical medical anthropology and primary care. Although the research started by looking at the individual level, the profound impact of structural factors meant that it was necessary to incorporate a structural perspective into my research.

Because I wished to focus my analysis at both the structural and the individual level, the thesis took a theoretically informed approach from the outset. I brought together two theoretical perspectives – ‘candidacy’ (Dixon-Woods et al 2005) and ‘structural vulnerability’ (Quesada et al 2011) to consider, how together, they might offer a method for exploring all the levels at which the health of vulnerable individuals is affected.

In Chapter Nine, the discussion, I reflect on both the overall findings of the thesis and the process of conducting the research. I start by briefly answering the research questions posed at the beginning of the thesis (Section 9.1). I then explore in greater detail, two of the most significant findings of the thesis: in Section 9.2 I suggest extensions to the candidacy model and in 9.3 I advance the notion of the UK asylum system as a determinant of ASR health. Section 9.4 offers a reflection on some of the challenges of conducting research with marginalised groups and Section 9.5 explores the strengths and limitations of the research. Finally, in Section 9.6 I offer recommendations for policy, public health practice, and further research.

9.1 Research questions

1. What does being ‘healthy’ mean to asylum seekers and refugees from Sub Saharan Africa in Glasgow?

ASR participants drew on biological, behavioural, and structural explanations when describing what it meant to be healthy, often switching between different accounts over the course of a conversation. While there was clarity on what health practices might contribute

to, or detract from, a healthy life in broad terms, participants were less certain about the links between health practices and specific NCDs.

Many of the ASR participants drew on individualised notions of health and prevention, underscoring that it was up to individuals to choose whether or not they were healthy through the practices they engaged in. However, while health practices were considered to be an individual choice, ASRs emphasised the numerous structural factors that precluded them from making those choices.

ASRs described a transition between their perceptions of health and wellbeing prior to arrival in the UK and now that they were in the UK. In their countries of origin, the participants had tended not to think actively about health unless they had an acute problem. Furthermore, health practices, such as those related to diet and exercise were considered to be an intrinsic part of life rather than requiring any particular effort. They acknowledged that in the UK, where the maintenance of health required (and was expected to require) active engagement, this was not the case. However, healthy choices were not necessarily the most accessible or most obvious ones, but required seeking out. This switch from considering health in an active rather than a passive manner occurred at a time when there were many constraints on ASR agency.

2. What are ASR experiences of using primary and preventive health services?

Most of the ASR participants found engagement with primary healthcare to be positive, at least initially. Although there were exceptions, the vast majority had experienced a smooth process of registering with primary care services, and had a GP practice within walking distance of their home. For many this initial positive experience was maintained with participants feeling considerable gratitude both to the healthcare system in the UK, and to individual doctors. There were areas of concern however. The first of these related to mismatching of expectations. In particular participants found appointment booking systems to be complicated and the length of time between the initial request and the actual appointment to be unsatisfactory. Secondly, language-related concerns were raised. This was an issue not only for those participants who spoke little to no English, but also for those who struggled with the technical language of healthcare consultations but were not obviously in need of an interpreter. For those who did use interpreters, concerns were expressed about the competence of the interpreter (both in terms of technical medical

language and language competence in general), and the way in which it altered the doctor-patient relationship.

Preventive health and preventive healthcare were considered to be new concepts, since as described above, participants were used to considering their health in acute situations. They were, however, concepts that resonated in theory. For many of the female participants, engagement with preventive health services came through the medium of screening for breast and cervical cancer. Most participants had taken up screening invitations, although some expressed concern about the unwanted side effects of screening.

3. What impacts on ASR capacity to keep healthy and access healthcare services?

ASR experiences of health and healthcare services were influenced by a multiplicity of meso- and macro-level factors. While many of these operated to increase ASR vulnerability, there were some protective structures as well. One positive aspect (though not one that should be overstated since negative attitudes exist also) is the policy context in Scotland. Integration starts at the point of arrival in Scotland, not on receipt of refugee status. In particular, NHS GGC has put structures in place to facilitate GP registration, and a commitment to provision for ASRs as a part of the equalities agenda. For many, though not all, participants, this context had a positive impact on their general wellbeing and on engagement with services.

This positive structure was challenged by many of the negative influences acting on ASRs, however. Some of these were related to their positions as refugees and asylum seekers, and some were exacerbated by it. The immigration and asylum system had a profoundly negative effect. This was particularly acute for asylum seekers but was not forgotten on receipt of refugee status. The asylum system left individuals in a place of extreme vulnerability with little control over their lives, subject to mistrust (and therefore anxious about engaging with authorities), and living in poverty. As well as negatively impacting on wellbeing in a general sense, this also shaped the ways that participants were willing to engage with services and health practices. These factors were compounded by racial discrimination, and a media/ public environment in which migrants are often treated with hostility.

Capacity to keep healthy and access healthcare services may logically have been expected to be shaped by the perceptions of those peers with whom ASRs engaged. Supportive non-

governmental structures (e.g., integration networks) provided spaces for ASRs to meet and discuss shared experiences. However, although many friendships were made within these groups which had a positive impact on wellbeing, the participants rarely talked about socialising with other ASRs *outside* of the context of these groups. Therefore, while perspectives on many issues, including health, were discussed with other ASRs within more formal settings, potential for ASRs to act as sources of informal social support for each other was, if not non-existent, significantly more limited. This suggests that healthcare interventions that rely on informal channels may not be appropriate without modification since there are limited informal opportunities through which perceptions of candidacy could be shared. The relative lack of sources of informal social support was likely shaped by the negative impact of being an ASR. As noted previously, since the demolition of the Red Road flats, asylum seekers were dispersed around the city, rather than living in close proximity to each other. This meant that public transport was required in order to socialise. Participants regularly discussed the prohibitive cost of transport around Glasgow suggesting that they were unlikely to use it unless reimbursement was guaranteed. Therefore, formal support had a larger presence in ASR lives, and a greater impact on capacity to keep healthy, than did informal support.

4. How do health professionals in Glasgow talk about refugee health and access to care?

Both the public health and primary care participants, many of whom had chosen to work in this field, expressed considerable commitment to addressing the health needs of ASRs, and were keen to highlight the projects that NHS GGC was already involved in. They also expressed support for migrants and refugees in general. Perhaps unsurprisingly, given the significant socioeconomic challenges already present in deprived areas of Glasgow, these participants emphasised the influence of poverty on ASR experiences of access and engagement with services. The role of culture was also considered to be important in shaping expectations and approaches to care. Professional participants were less likely to consider the culture of NHS GGC or of healthcare professionals, however, focusing instead on the culture of the service users. Professionals play a role in determining what needs ASRs have, and it was also suggested that it was easy to make assumptions of need based on an individual's identity as an ASR and focus on the immediacy of their situation, without considering what other needs they may have.

9.2 Developing the Candidacy framework

Candidacy was developed with the express intention of illuminating the pathway to healthcare for ‘vulnerable’ groups (Dixon-Woods 2005) and so it was a natural starting point for research with refugees and asylum seekers who might be described in this way. One of the aims of this thesis has been to test the utility of the theory of candidacy (Dixon-Woods et al 2005) both in terms of how well it can help us understand access to preventive care and also in terms of how useful it is in the context of this particular study population (ASRs). Chapter Six considered how ASRs identified themselves as putative ‘candidates’ for preventive services by exploring their understandings of what it means to be healthy and of how they thought about chronic diseases, such as CVD and diabetes. Chapter Seven – access to and engagement with care – drew explicitly on this theory in elucidating the access-related experiences of refugees and asylum seekers in Glasgow. In exploring access to primary healthcare and preventive health, candidacy, as is evidenced in the results chapters, proved illuminating and proved that it has salience beyond its original intention of theorising access to primary and hospital-based care services. However, to account more fully for the experiences of refugees and asylum seekers, and to adopt the more holistic approach required when considering prevention, the candidacy framework requires a degree of modification or extension.

9.2.1 Extending candidacy to prevention

Candidacy was initially developed to describe access to healthcare services for physical conditions, and whilst it has been extended to consider access to services in other arenas, such as mental health and domestic violence services (Kovandzic et al 2011; Mackenzie et al 2011), thinking about prevention necessitates an additional step. Prevention involves not only access to preventive interventions (such as weight loss or exercise interventions) but also access to the means through which individuals are able to engage in ‘healthy’ practices such as healthy eating, exercise and developing social connections. To engage in preventive health practices requires not just the identification that health-related activities are relevant and a willingness to take part in them, but also that the structures are in place to enable us to do so. Preventive practices are not simply issues of ‘behaviour’, but issues of access as well, and the candidacy model provides the opportunity to look at how these two factors interact. Candidacy can therefore be illuminating for examining preventive practices, albeit in a manner that might not have been intended when it was developed. The critiques of candidacy discussed in Chapter Four (e.g., that it is not linear, that it doesn’t

account for multiple candidacies, and that it insufficiently considers structure) are also relevant here.

A further extension builds on the work of Chase et al, 2017, who mapped access journeys amongst asylum seekers in Canada. They found that healthcare professionals and community workers could play a role in helping ASRs identify themselves as candidates for care, by highlighting ASR entitlements. Professionals arguably have a similar role in the prevention journey, developing awareness of NCD risk in ASR communities, and highlighting entitlements that they may not be aware of (e.g., free swimming pools).

9.2.2 Using the theory of structural vulnerability to enhance understanding of candidacy.

Both preventive health and health promotion have traditionally been considered in individualist terms, with the emphasis on people's own responsibility to self-regulate and keep themselves healthy (Raphael 2013). This stands in contrast to the large body of research on the social determinants of health, which suggests it is the 'conditions in which we live, work, and play' (Marmot 2010) that have the most profound impact on our health, with change at the individual level extremely challenging without change at other levels as well [though see critiques in Chapter Four]. There is, therefore, scope to consider prevention from a structural perspective in addition to an individual one (Rhodes et al 2013). Previous critiques of the candidacy model have documented the lack of space to explore how structural determinants impact on the process of accessing healthcare (Mackenzie et al 2011; Kovandzic 2011) and one approach to overcome this has been to analyse data using an additional theory such as intersectionality (Mackenzie et al 2015).

I sought to address this by integrating candidacy with Quesada et al's theory of structural vulnerability (as elucidated in Chapter Three), drawing attention to the way in which political, social and economic structures intersect and place people in positions of vulnerability to poor health (Quesada et al 2011). An important aspect of the structural vulnerability lens that extends it beyond traditional SDH frameworks is that it also encourages a consideration of the role of power and resources in shaping outcomes. This is critical when looking at interactions between marginalised individuals with little power and few resources and a system with a considerable amount of both. I discuss below, with reference to the stages of the candidacy framework, how the candidacy process might be reconceptualised. I then offer a modified version of the candidacy framework.

9.2.2.1 Identification

The point at which an individual identifies themselves as a candidate for healthcare.

Mackenzie et al note that the process of identifying candidacy is more complicated with preventive care, since the starting point is the health service defining a particular group as at risk (2011:352) and individuals then deciding if they also consider themselves in this way. This was certainly evident in the ways that some of the participants discussed screening practices, with some unconvinced they were appropriate. The role of structure in identifying whether individuals were candidates for preventive interventions was clear. Perceptions of what being healthy meant were shaped by the position of being an ASR with very few resources and, for asylum seekers, almost no control over their future. As described in Chapter Six, participants understood that the path to good health lay in practices such as healthy eating and regular exercise. However, while this was considered to be a general good, they did not necessarily identify these practices as being relevant and worthwhile to them. This could be attributed to a plethora of structural reasons, but in particular poverty, discomfort being visible in the local area, and the all-encompassing nature of the asylum process were important.

Acknowledging that a practice is important in general terms also requires it to be culturally salient. Participants were moving from a position where active engagement with food and diet was not the norm to one where, although ideal dietary and exercise practices might be more difficult to enact, societal discourse expected it. This change also required a shift in the identification of candidacy so that these practices had relevance to participants. Thus, perceptions of candidacy can shift both consciously and unconsciously. This may suggest a role for others. For example, as identified by Chase 2017, health professionals or community advocates, who have more resources to draw on, may help to shift perceptions.

Precarity, shaped by the experience of being a forced migrant and living in poverty, also shaped how professionals viewed asylum seekers' candidacy – when there were so many clear and pressing structural issues, which rightly required attention, other health matters came to be considered as secondary. As noted in Chapter Seven, Melanie, a GP suggested that when she saw a patient who was an asylum seeker it was the structural, rather than health issues that were paramount in her mind.

9.2.2.2 Navigation and permeability

The route to entry into a particular health service; the work an individual must do to get there; and the ease with which they can access a service.

Navigation requires the awareness both of what services or opportunities are available, and the capacity to reach those services. In the context of preventive practices such as consumption of healthy food or exercise, navigation and permeability refer to how easy it is to enact those practices. This might relate to proximity to supermarkets that sell cheap, healthy food, which varied considerably for the refugees and asylum seekers depending on the part of Glasgow they resided in. Exercise facilities were similarly difficult or easy to navigate. Some participants lived close to gyms that provided free or discounted access, or close to green spaces where exercise was possible.

Structural factors played a significant role, however, in determining how easy it was for individuals to navigate services and practices, as well as how permeable they were. The more axes of vulnerability acting on an individual, the more work was required to access a service. For example, while healthy food is ostensibly available (in the same way that a health service might be), being able to obtain it requires significant resources and can therefore be considered as an issue of permeability. Several participants remarked on the challenge of purchasing healthy food when it was considerably more expensive than the alternative, and it was therefore not a practice they engaged in on a regular basis. Many participants used food banks as a means of circumventing this issue. Again, however, food banks were more or less porous, with different food banks having different requirements as regards what was needed to qualify to obtain food. Access to exercise and social connections can be similarly understood in the context of permeability. While an exercise opportunity might be considered permeable on one level (e.g., free access to a swimming pool), the cost required to purchase a swimsuit, as Mary Anne a public health professional noted (Chapter Six), might negate this fact. Considering access to social connections, a challenge for participants was the cost required to attend a particular community group or activity. If an individual was required to travel to take part in an activity, their ability to do so was predicated on whether they would be reimbursed for their travel expenses. Vulnerability related to discrimination and ‘othering’ was clear here too. Even if participants did have access to open spaces or free activities some felt uncomfortable in these spaces due to a concern that they were overly visible.

Structural vulnerabilities influenced permeability of traditional health services in a similar way. The same activity, for example, telephoning to make an appointment, required significantly more work for an asylum seeker who had limited phone credit and limited English, compared to someone who did not experience those barriers.

9.2.2.3 Presentation, adjudication, and offers and resistance

The act of asserting candidacy at a health service, either through an individual's own decision or by an intervention; professional judgement as to whether an individual should be a candidate for a particular service; the point at which offers of care are made

ASRs in Scotland are caught between two very different narratives, both of which can impact on their willingness to present to services. The first is the narrative displayed at a UK government-wide level, and mirrored (and exacerbated) in the media and public opinion, that ASRs (and migrants more generally) are untrustworthy and a drain on resources. The potential effect of this is that refugees and asylum seekers do not feel comfortable engaging in practices that make them overly visible to the general public or offer the impression that they are taking up too much space. The second narrative is a protective one which is the strong advocacy provided by the plethora of community organisations that support refugees and asylum seekers. This may suggest to ASRs that they are a valued part of the Glasgow community and thus encourage engagement on other levels as well.

Again considering prevention, presentation and adjudication might relate to how comfortable an individual is engaging in a certain practice or being in a certain place, and thus overlaps with permeability. Several female participants spoke of their reluctance to exercise outdoors due to concerns for their safety. Reasons included their visibility as foreign black individuals who might be disturbing others people's spaces but also concerns around the isolation of exercise areas. These all present barriers to 'presentation', and to the actual enactment of the health practice.

9.2.2.4 Operating conditions and local production of candidacy

The local influences on both patients and practitioners that affect the production of candidacy

Rather than a separate stage in the candidacy process, operating conditions and the local production of candidacy colour every one of the previous stages. While extremely important in identifying the meso-level influences impacting on candidacy, the theme of operating conditions within Dixon-Wood's original conception does not provide sufficient space to theorise the structural influences on access to care or preventive practices adequately. To address this, and to ensure that the framework of candidacy can truly account for issues of vulnerability and marginality, the concept of candidacy requires further extension to place access in its structural context. Based on the incorporation of structural vulnerability into the candidacy framework, and following Mackenzie et al (2013)'s calls to expand operating conditions to include macro-level factors, I present a modified version of the candidacy framework below.

In this modified version of candidacy, the stages of the process have been reconceptualised in a circular format. This is to emphasise that candidacy is cyclical rather than a linear process, and that multiple candidacies may coexist for access to different services. While there may be a typical candidacy pathway – from identification, through to navigation and permeability and then on to presentation, adjudication, and offers and resistance (as demonstrated by the larger red arrows) – the candidacy 'journey' does not always follow this neat, linear pathway. Often the process is iterative, with consequent blurring between the different stages. This is illustrated first by the smaller grey arrows and second, by collapsing candidacy into three broad areas of identification; navigation and permeability; and presentation, adjudication, and offers/resistance. The inner part of the diagram thus describes the negotiations between service user and service provider over access to preventive practices and health services.

As presented here, the final stage of the original framework – operating conditions – influences the entire candidacy process. Therefore, in this modified version, operating conditions are no longer conceptualised as a stand-alone stage at the end of a notionally linear journey, but instead wrap around the entire process (in light yellow). The dark yellow arrows indicate how meso-level operating conditions make an impact on the other elements of candidacy.

Finally, the blue outer layer demonstrates the impact of structural factors, thus accounting for one of the key deficiencies in the original model. Here the dark yellow arrows demonstrate how structural factors create vulnerabilities in the candidacy process. The candidacy journey can be affected directly by these structural determinants, as well as

indirectly through the operating conditions. A number of potential structures are listed although this is not exhaustive. Each of these structures has an impact on its own, but also intersects with the other structures (as demonstrated by the thin red arrows) to further compound vulnerability and impact on candidacy.

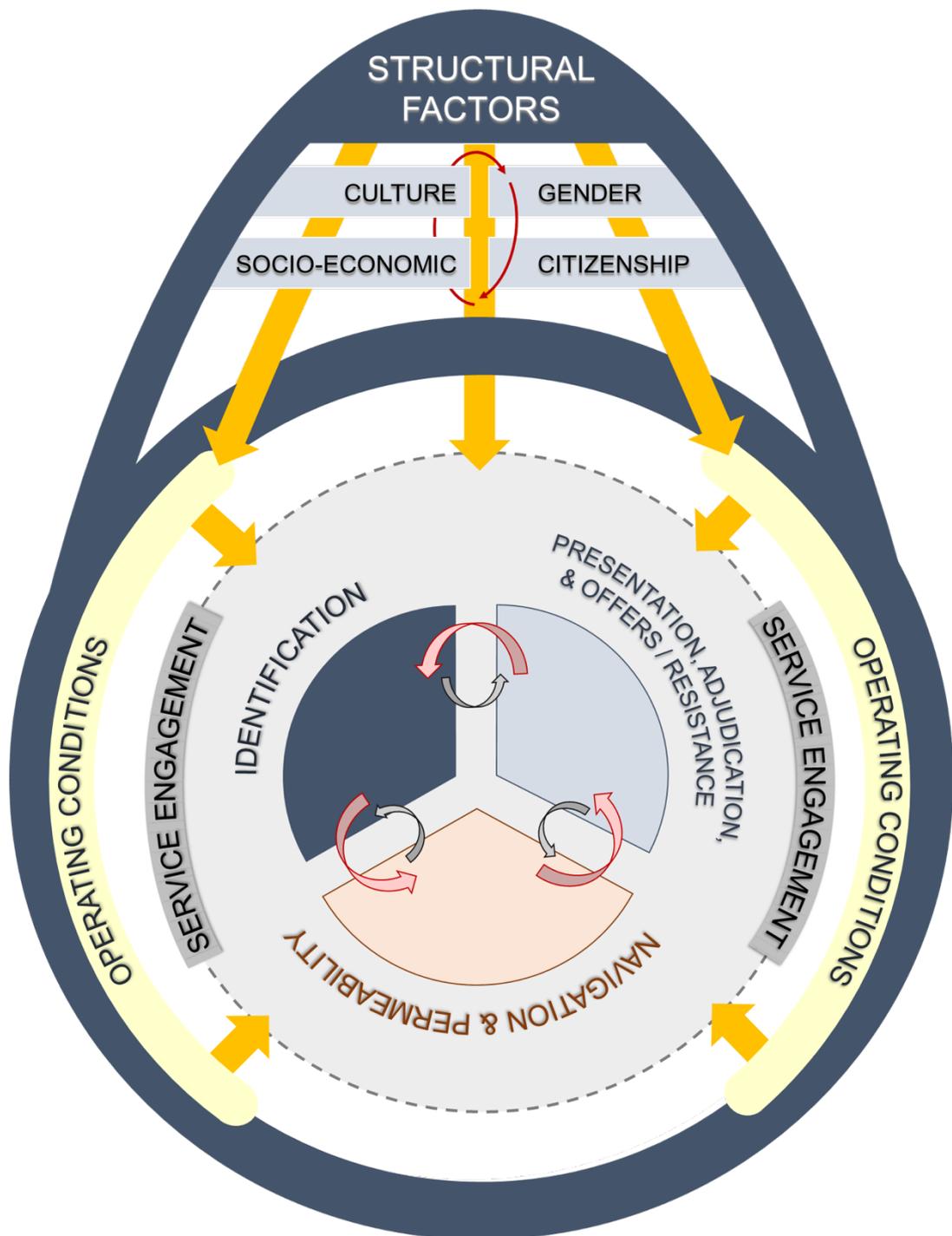


Figure 7: modified candidacy framework

9.3 The asylum system as a determinant of health

Drawing together candidacy and structural vulnerability provides a model that is useful not only for understanding the experiences of ASRs, but also for other potentially vulnerable groups. However, there is one clear additional factor that contributes to the ASR experience – the UK asylum and immigration system itself. Although academic research in migrant health has traditionally focused on culture (Sargent & Larchanché 2011:354;

Viruell-Fuentes et al 2012), studies have increasingly looked at the social and political determinants of migrant health, with a small body of work exploring the role of migration as a key determinant (e.g., Castañeda et al 2015; Fleischman et al 2015). Research has previously suggested that immigration processes in the UK and worldwide can have as much of an impact on refugee mental health as previous trauma, if not more (Carswell et al 2011:108; Martinez et al 2015:965). The findings of this study add to this literature in demonstrating that the UK immigration and asylum system (I refer here specifically to the effects of the legal process rather than the broader migration experience, though they are interlinked) has a significant potential to affect not only mental health, but also physical wellbeing, access to the means of prevention, and people's capacity to live fulfilling and healthy lives during and after the asylum process. Since Scotland has put in place a number of policies that seek to counteract the negative effects of the asylum system it is not inconceivable that these negative effects would be even stronger in dispersal cities outside Scotland.

While asylum seekers and undocumented migrants in the UK have entitlements to NHS access that are not necessarily enjoyed in other countries (Fleischman et al 2015:90), this is tempered by a number of factors. Particularly important are those legal processes that have sought to limit care – the introduction of healthcare charges for certain types of migrants in England (Worthington 2017) and attempts by the Home Office and UK border agency to co-opt medical professionals into passing on the immigration status of their patients (doctorsoftheworld.org.uk). While the implications for Scotland are unclear, the rhetoric will be of concern to asylum seekers (particularly those whose application has been denied). Many have noted how legal status has been used as a means through which either to provide or to deny access to care (e.g., Cartwright et al 2011:476). Although healthcare is technically offered to individuals in Scotland irrespective of immigration status, UK government actions serve to subvert this through introducing an element of fear into the health-seeking process. In this way legal status acts as a mechanism through which care is either sanctioned or denied. There are, in fact, increasing reports of women in England presenting at the Doctors of the World-run clinic for irregular migrants, nine months pregnant and having received no previous medical care (Harvey 2017).

As demonstrated in the findings, the immigration system acts as a determinant of refugee and asylum seeker health in a broader range of ways than just compromising access to care, operating a form of structural violence and placing individuals in a space of heightened risk. The UK asylum system, entirely intentionally, acts to make life

uncomfortable for both waiting and failed asylum seekers (Mulvey 2015). The result is an existence where individuals have limited control, little idea of what may happen to them and when, hugely constrained access to resources, and where they are the subject of suspicion and racial discrimination (reinforced through the media and public perception). These factors intersect so that refugees and asylum seekers are left in a constant state of anxiety, unable to access the resources that would afford them the opportunity to live a healthy life and maximise their chances of preventing chronic disease.

Until relatively recently, recognition of refugee status has provided a level of security and stability. Even if not all of the negative effects of the asylum system were reversed (Kearns et al 2017), refugees were able to start to invest in, and establish control over, their lives. This security was undermined, however, by a change in policy in 2005 which meant that refugees were initially only offered five years leave to remain, with permanent residency considered after this period (Kearns et al 2017). The UK government announced in early 2017 that confirmation of this status – which had previously been considered a formality – would now involve a full assessment of the refugee's continued right to residency (Yeo 2017). Given the evidence that the anxiety caused by a pending asylum application has detrimental effects on health, the fact that refugees will now remain in a state of insecurity for a further five years has concerning implications.

If one considers access to the means of prevention as equally relevant for health as healthcare, then the government is abdicating its responsibility to asylum seekers and refugees (and also many others) to provide an environment in which individuals can access the means to enable them to be healthy. The degree of health inequality in the UK demonstrates that this is an issue not just for refugees and asylum seekers but for a number of 'communities' that are politically, socially, and economically marginalised.

9.4 Reflections on research with marginalised groups

Conducting fieldwork with ASRs brought with it a number of challenges at different stages in the research process and raised several ethical questions. Here I reflect on the complexity of conducting research with marginalised groups focusing in particular on i) recruitment, ii) using an interpreter, and iii) ethical challenges including the requirement to provide identifying data to NHS Research & Development, and managing participant expectations.

9.4.1. Recruitment challenges

Refugees and asylum seekers are often considered to be a 'hard-to-reach' group. Although this notion has been contested, with arguments that the term 'easy to ignore' is more appropriate (Matthews et al 2012:43), several challenges did present in the recruitment process. Although I eventually recruited 27 ASR participants, there were many false starts along the way, particularly at the level of community group engagement. There are rightly concerns about over-research amongst marginalised groups in Glasgow, and understandable suspicion about the intentions of researchers. It was therefore necessary to establish trust by underscoring my commitment to the participants in the study.

Importantly, however, many community groups are under considerable pressure, with insufficient funding to meet their aims, and so even after these discussions, maintaining contact was difficult. There were a number of groups where, after offers of support were made to me, communications ceased and it was necessary to seek out alternative avenues.

Given initial engagement challenges, I could not be overly prescriptive about the demographics of the participants (beyond them being an ASR from a country in Sub Saharan Africa). It was particularly difficult to recruit men, who in Glasgow tend to be less well connected with community organisations (Strang & Quinn 2014:5). While I did manage to interview both men and women across a range of ages, the majority of the women I interviewed were over the age of 40 whereas the majority of men were under the age of 40. This (along with differences related to gender and previous experience) meant that they approached ideas about their health from a different standpoint. Additionally, unlike the women, all but one of whom came from countries where some level of English was spoken, most of the men (seven of the ten) did not speak English and were further isolated as a result.

9.4.2 Interpreted interviews and establishing rapport

The use of an interpreter for interviews with seven of the men added a layer of complexity to the interview process. I was keen to draw on the community links I had made and so recruited an individual who had assisted me with recruitment to interpret the interviews. This afforded me access to a number of individuals who I probably would not have recruited otherwise (he was in touch with individuals who did not regularly attend more mainstream community organisations). However, I did have concerns that his proximity to the participants as an advocate for their needs, combined with his investment in my

research, meant that he was overly involved in the conversations, rather than simply translating my questions and the participants' answers. Although we discussed this, and I was confident in his translations, there was much conversation that took place in addition to the interview. While I sensed that he was trying to provide added context to the questions I was asking, it is, of course, impossible to know exactly what is being said in another language.

The presence of an interpreter changes a two-person dynamic into a three-person dynamic which has a significant impact on the ability to establish rapport (Greenhalgh et al 2006). Although participants in the interpreted interviews spoke about a number of difficult personal issues, I did not feel that our conversations were able to reach the same depths as those conversations between just myself and the participant. Although frustrating, this provided important insight into the experiences of those participants who are forced to conduct their lives through interpreters.

Other intersecting factors also coalesced around these individuals: language, precarity, gender, and culture. A number of the men I interviewed through an interpreter were in particularly precarious positions, either destitute, or moving through the asylum system for a second or a third time. Even those who had refugee status were struggling, since without English it was incredibly difficult to obtain any employment. They existed at the margins to such a degree that many of the questions I asked felt irrelevant. Interviewing challenges were compounded by a gender dimension. Interviewing both men and women, it became very clear to me that the interviews with the women achieved a significantly greater depth than those with the men, perhaps due to the implicit understanding of a level of shared experience relating to health and wellbeing and life more generally. In talking about cervical screening tests, for example, one participant asked me if this was something I had engaged in; another shared photos of her young children. As discussed in Chapter Four, while the traditional notion of an interview has emphasised a passive and objective interviewer, this does not (and nor should it) reflect the reality of the participant-interviewer relationship. My status as a woman allowed the female participants to open up to me in a way that the men did not.

9.4.3 Questioning formal ethics procedures

Consideration of ethics in qualitative fieldwork should not end when ethical approval is obtained. The process of gaining approval is in itself worthy of scrutiny, since tension can

occur between established ethical principles and the real life practice of research (Guillemin & Gillan 2004:269; Webster et al 2014:82). In particular, it is important to consider whose interests, exactly, ethical procedures protect, and how problematic power dynamics (at multiple levels) might be replicated through these procedures. The process of obtaining ethical approval, whilst an extremely important part of conducting research, raised wider concerns in this regard. Much of this centred on the requirements for NHS R&D approval. Although my refugee and asylum seeker participants were not recruited through the NHS, the fact that I was also interviewing NHS staff meant that the NHS became sponsors of the entire study, and the NHS logo was required on all my documentation. This could potentially have been confusing for participants to whom I had introduced myself as an independent university researcher, with no ties to government agencies or similar. More concerning was the requirement that the NHS retained the right to obtain any of my research data (including participants' personal information) for audit purposes. Having gone to considerable lengths to demonstrate how participants' personal information would be kept secure and all data would be anonymised, I felt extremely uncomfortable having to state this on my forms.

The NHS's right to obtain research data raises numerous concerns, both in terms of doing research with potentially vulnerable individuals and also with members of NHS staff. My asylum seeking participants did not have settled immigration statuses, and many may have had a justifiable fear of government authorities, based both on experiences in their home countries and potentially also with immigration officials in the UK. Whilst the collection of data for audit by the NHS might be routine and innocuous, participants certainly could not be blamed for considering that information might be passed between different organisations and end up in the hands of Home Office officials. Indeed, with UK border enforcement increasingly reaching into numerous areas of service provision, including the NHS (Yuval-Davis et al 2017), concerns of this type may well be justified. This clause on the information sheet might have made individuals reluctant to talk to me, or conversely made them feel that they had to appear in a particular way, in case it might help them with their asylum claim. In respect of the NHS professionals to whom I was speaking, it is unlikely that an NHS member of staff will say anything 'off-record' if there is a chance that their identified interview might be read by another member of NHS staff, even if only for audit. Keen to get underway with my research, and unsure of what options I had as a PhD researcher, this clause remained on my recruitment material. It does, however, raise serious questions about whose interests are being served by ethical approval practices.

9.4.4 Ethics in practice: meeting expectations

Conducting research with a group that is deemed ‘vulnerable’ or at the very least occupies a marginalised social position poses numerous ethical and methodological conflicts about what level of responsibility one has to one’s research participants. There are many tales of researchers who arrive at an organisation, are granted access, take up participants’ time and subsequently disappear, never to be heard of again. Not only do they make it difficult for researchers who arrive in their wake, but it shows a considerable lack of respect for individuals who have taken time to share information, and rightly hope that it might contribute towards positive change. If it is agreed that such a limited engagement is unacceptable, the question becomes when can one feel confident that they are indeed making a positive contribution to research participants significant enough to justify the disruption to their lives? Is foregrounding the words of participants whose views are often marginalised sufficient? Is engaging in participatory research methods that shift the power balance between researcher and researched doing enough?

More than once during my fieldwork I was concerned that potential participants might overestimate my capacity to improve their situation and agree to take part on those grounds. Although I tried to make it as clear as possible that this was not the case, at least in any immediate way, many of the ASRs existed in precarious situations and hoped I would be able to effect tangible and immediate changes in their lives. Following a group event where I explained the research I was conducting, a member of the group stood up to say that everyone should participate, since the Home Office would look more favourably on individuals who were involved in and engaged with as many activities as possible. Later on in my fieldwork, a participant who, having had his asylum application rejected, had been homeless and destitute for five years, mentioned at the end of the interview that he came in part in the hope that I might be able to help his situation in some way. However, aside from directing him to medical and dental services, and providing him with a £15 voucher, I was of course, powerless to change his situation. While creating tangible change is certainly a long term research goal, this does little for someone who can only think as far ahead as the hostel they will be staying in that night.

While giving marginalised individuals a voice is valuable in itself, in a field that is often overcrowded with researchers hoping to make a difference, it is important to remain critically aware of our own roles, be honest about what we can realistically achieve and remain cognisant of what participants might be expecting. Researchers go to significant

lengths to ensure there is no coercion in the recruitment of participants, and by overemphasising, however inadvertently, the positive changes we might be able to bring about, we are liable to disappoint individuals who have put a significant amount of trust in us.

9.4.5 Ethics in practice: paying participants

It is important to consider the ethics of and motivation for offering money to research participants, a topic about which there is limited consensus in the social sciences (Wiles et al 2005 in Webster et al 2014). It is certainly not ethically straightforward, since it brings into question issues around free consent and concerns that participants might give the answers expected of them, rather than the express how they actually feel (Head 2009:336-343). Participant payment has proved a useful tool in aiding study recruitment however, and can be a useful way to thank participants for their time and energy (ibid). Indeed, Head notes that some feminist researchers have considered payment to be an ethical obligation, since it is one way of helping to subvert the unequal power balance between researcher and researched and ensure that it is not only the researcher who is benefitting from the project (Head 2009: 337).

Since both the refugees and asylum seekers participating in my research were existing in varying situations of precarity and financial hardship, and because they were providing me with both their time and energy, I felt it appropriate to give a token to thank them for taking part. Of course I cannot be sure of the extent to which this influenced their willingness to participate, but for those existing on an asylum budget, a £15 voucher does make a significant difference. At the Ketso sessions I provided refreshments and reimbursed any travel expenses. The two organisations I engaged with also reimbursed travel expenses and provided refreshments when running events, so this would have been expected, and most of the participants would in fact have been unable to travel to the session if required to pay for transport themselves. I subsequently offered a £15 Tesco voucher to all interview participants. Rather than payment for a service I considered this to be a token of appreciation for having taken up their time.

9.5 Strengths and limitations

The research conducted for this thesis contained both a number of strengths and limitations, which I outline briefly here.

The research had several important strengths. In terms of recruitment, despite challenges (Section 9.4.1), I was able to engage with a wide range of individuals, including some who were in particularly vulnerable positions and had had little opportunity for their voice to be heard previously. Further, the range of methods utilised in the focused ethnography allowed for considerable depth and triangulation of data. I was further able to add depth by interviewing professional as well as ASR participants. Additionally, by conducting participatory focus groups and walking interviews I was also able to add a participatory element to the research. This helped ensure that I was led by the participants' perspectives, rather than the other way around. This was particularly important given the aforementioned vulnerability of some of the participants. Finally, the integration of two theoretical perspectives – candidacy and structural vulnerability allowed me to make important insights not just in terms of ASRs, but also for conducting research with a variety of vulnerable groups.

One aspect that could be considered either a strength or a limitation, related to the differences between myself and the ASR participants. Although the participants came from a variety of cultures (and so it would have been impossible to match all of them), it was very clear that I did not share either their heritage or experiences, being white and, though not from Glasgow, born in the UK. Because my background was so different from theirs, there may have been significant potential for misunderstanding. Additionally, the participants might not have felt it appropriate to share some of their experiences with me. For example, while African's in Glasgow have been noted to utilise traditional medicines (Cooper at al 2012), only one participant mentioned this to me, and only in reference to others not herself. However, being an outsider also brings with it a strength, which is that I was able to critique notions that may have been taken for granted by individuals with shared cultural norms.

A second set of limitations related to recruitment. Firstly, I was not able to get an entirely representative sample of Africans in Glasgow and so while some groups were well represented (e.g. young Eritrean men), others were not (e.g. men from other African countries). Further the age and gender split of the made comparison difficult. Lastly, because I carried out recruitment through community groups, those ASRs who were most marginalised were effectively excluded from the study. It was necessary to be cognisant of this when developing the arguments in the thesis.

A final limitation was methodological. One particular weakness was that I was only able to carry out three walking interviews which was significantly fewer than anticipated. In some cases, this was because the weather was too inclement for me to ask the participants to come on a walk. Other participants had children at home and were not able to participate for that reason. One other felt that she would be too conspicuous walking around the neighbourhood and declined for that reason. As a result, I was unable to obtain as good an understanding of the geographies of individuals' lives as I had wanted. A related comment, however (discussed in Chapter Seven) is that the participants did not live their lives within the small area around their homes, but were more likely to travel in and out of the area to specific locations. Therefore, to fully account for the spaces in which the ASR participants lived it would have required much more than a walk around their neighbourhood.

9.6 Research implications and recommendations

The findings of this research have implications at a variety of different levels from those that relate to UK immigration policy as a whole, to those that are relevant for public health and clinical care.

9.6.1 Implications for UK asylum policy

This thesis has demonstrated how the immigration and asylum system creates and exacerbates the conditions for poor health. It therefore provides added evidence to support calls from a variety of bodies, including both the English and Scottish Refugee Councils, to create a more humane asylum policy by demonstrating the clear negative public health implications of the current system. While the UK government has less direct control over what happens to individuals before they reach UK borders, it does have power over what happens to asylum seekers once they are in the UK. It can, and should, exercise that power in a way that underscores its obligations to respect all individuals' rights to healthcare and to the conditions that would allow them to stay healthy. Strategies to limit the vulnerability that is imposed on asylum seekers by the immigration system should address the poverty and agonising limbo in which individuals are forced to live.

9.6.2 Implications for Scottish integration policy

Glasgow has a reputation for being an extremely friendly city. A plethora of organisations exist to serve refugee and asylum seeker populations, and they are reinforced by an

integration strategy that starts from the moment an individual arrives in the country. However, neither Glasgow's status as a friendly city, nor the level of support that has been displayed can negate the reality that racism and racial discrimination do still exist, and colour the lives of participants who feel 'other' both because they are black and because they are migrants. While ASRs, and indeed other ethnic minorities, might feel welcome on certain levels, there are still many ways in which they are cast as outsiders. It is therefore crucial not to be complacent, but to make concerted efforts to continue to combat both institutional and individual racism, and to ensure that Glasgow's reputation as a friendly city is able to extend beyond superficial levels.

An important finding of the thesis was that the geographies of refugees' and asylum seekers' lives did not necessarily correspond to the physical geographies in which they lived. It is important, therefore, to gain a clearer idea not just of where ASRs (including those who are destitute) are living, but also where they are frequenting, so that service provision can be directed appropriately. Related to the findings on integration, where fear about being visible in the local area is inhibiting refugee and asylum seeker movement, work needs to be carried out to address these concerns. This is particularly complex given that many of the area in which refugees and asylum seekers reside are in the most deprived areas of Glasgow with numerous attendant social issues.

9.6.3 Implications for the NHS

As mentioned above, this thesis highlights the role of the asylum system not only as a determinant of mental health, but a determinant of physical health as well. The NHS therefore has a role to play in mitigating some of the damage inflicted at that level. Two suggestions are:

- Committing to (and vocalising) a complete separation between the NHS and UKBA so that asylum seekers can seek out care without fear.
- Using the NHS's voice, together with other professional medical bodies, such as the Royal Colleges, to highlight the detrimental effects of asylum policy on health.
- Professionals have the discretion to determine whether access constraints related to navigation and permeability can be lifted. For example, primary care or hospital services could choose to reimburse individuals who may have trouble accessing them without this.

Considering prevention, this research has sought to explore the path through which a marginalised community might access and engage with preventive health practices. The extended model of the candidacy process (described in 9.2) takes a broader understanding of the structural influences on engagement and thus provides a useful model through which to explore the barriers and facilitators to access to preventive practices. By situating preventive health in its structural context, ‘risk behaviours’ can be reconceptualised as a product of a structural rather than behaviour.

9.6.4 Implications for primary care practice

Dispersal of asylum seekers throughout Glasgow means that a larger number of GP surgeries now see patients from ASR backgrounds. Many may have had limited experience in this area, and may already be under severe pressure due to working in highly deprived areas of the city. Extra support needs to be provided to GPs, and the whole practice team, so that they are able to manage the diversity of expectations and experiences that they are faced with.

Refugees and asylum seekers are met with suspicion by immigration authorities in the UK and this can colour their experience of engagement with other service providers and impact on their candidacy journeys. GPs (and other healthcare professionals) can therefore play a role in modelling a relationship that is based on trust and openness so as to counteract the feeling, held by many, that as refugees and asylum seekers they were untrustworthy and unwelcome. The Scottish network, General practitioners at the Deep End, which brings together doctors working in the most deprived practices in Scotland³⁸ might provide a platform through which GPs can share their experiences of caring for ASRs and learn from one another.

Although not the most significant barrier, gaps in health literacy did exist for individuals who had transitioned to a different model of health services than that which they were used to. This reinforces the need for further work with refugee community organisations around rights and entitlements to healthcare and also what individuals can and can’t expect. Further, although refugees were clear on the types of practices that were useful for good

³⁸ Full ref:
<https://www.gla.ac.uk/researchinstitutes/healthwellbeing/research/generalpractice/deepend/about/>

health in a general sense, they were less able to link these to specific conditions for which they might be at risk. There is therefore potential for education outreach in this area.

NHS GGC has displayed strong commitment to interpretation through establishing an in-house interpreting service and underscoring the right of every individual to an interpreter. However, there are still gaps in interpreting or translation provision, where individuals end up feeling isolated, and their access to healthcare is compromised. These include letters of invitation to screenings or follow up appointments, or when individuals try to book appointments either by phone or in person. A further difficulty arises when individuals have sufficiently good English language to 'get by' but not to the extent that they feel comfortable in a medical setting which requires a very different set of language skills. GP surgeries should be made aware that individuals have a right to an interpreter at all times, not simply in the actual consultation. Additionally, work needs to be done to ensure that referral letters can be produced in the appropriate language.

A final implication particularly relevant for prevention would be for a greater focus to be placed on social prescribing for non-clinical services that may be important for health and wellbeing. There is potential to do this through the extension of the Scottish Links-Worker programme³⁹ by training links workers to address ASR wellbeing needs.

9.6.5 Further research questions

While many of the issues in this research touched on the specificities of life as a refugee or asylum seeker, there is clearly a commonality of experience not only with other ethnic minority groups, but also with other socioeconomically marginalised white populations, for example homeless populations, and those experiencing extreme poverty. It would be useful to conduct further research that explores where marginalised groups have similar experiences in order to strengthen the evidence base around the effects of inequalities on health.

This thesis presented a theoretical development by integrating candidacy (Dixon-Woods et al 2005) with the theory of structural vulnerability (Quesada et al 2011), and presenting a

³⁹ The Scottish Links Worker Programme is a government funded programme that aims to assist primary care to address the social determinants of health by placing Links practitioners in GP surgeries to help address the broader wellbeing needs of the patients (<http://links.alliance-scotland.org.uk/>).

modified version of the candidacy framework. There is potential to test this framework with other marginalised populations.

As the only dispersal city in Scotland, refugees and asylum seekers in Glasgow are in a different position to refugees and asylum seekers in the rest of the UK. While the laws related to the UK immigration system are the same across the UK, those pertaining to provision of healthcare and integration are not. It is therefore important to examine whether variations in these policies have an impact on the health and wellbeing of refugees and asylum seekers in Glasgow compared to other cities in the UK.

9.7 Conclusion

In light of concerns around our limited understanding of ASR perspectives on preventive care and health messaging (F Homji et al 2011; Norredam and Krasnik 2011), and in light of the potential for preventive interventions to exacerbate health inequalities (Beauchamp et al 2010; Mackenzie et al 2011; White et al 2009), this thesis sought to elucidate health perceptions, and healthcare related experiences of ASRs from Sub Saharan Africa living in Glasgow.

The thesis provides two main contributions to the public health and primary care discourse— one broader and more theoretical, and the other pertaining directly to the ASR experience. Theoretically, it has developed an adapted model of the candidacy framework (Dixon-Woods et al 2005) by integrating candidacy with considerations of structural vulnerability (Quesada et al 2011). With regards to the research in this thesis, this adaptation provided a useful means of analysing the range of influences – from the micro- to the macro-level – that shaped ASR access to and experiences of care. It also facilitated the inclusion of access to preventive care and preventive practices into the framework. More broadly, there is potential to test the utility of this adapted framework with a range of other vulnerable and/or marginalised groups.

In terms of developing understandings of ASR health, the thesis has contributed to literature that explores the role of migration as a determinant of health (Castañeda et al 2015, Fleischman 2015) by advancing the notion of the UK immigration and asylum system as a determinant of both physical and mental wellbeing. Interviewing ASRs about their experiences of health, wellbeing and access to care, the multiple and intersecting structural influences on their lives were clear both to me, and to the participants

themselves. The asylum system had the most profound impact however, both directly, and by compounding other structural influences. The asylum system intersected with several sources of vulnerability to diminish agency both at a psychological level (e.g. through placing individuals in limbo, casting them as the subject of suspicion), and also at a resource level (e.g. through enforced poverty, creating a barrier to communication). It also shaped how ASRs were viewed by public health and primary care professionals. In placing ASRs in positions where they were less able to engage in preventive care, and therefore at greater risk of chronic 'lifestyle' diseases, these structures enacted a form of violence against ASRs.

While affecting the organisation of the asylum system may be beyond the reach of public health and primary care, these disciplines have a responsibility to demonstrate where structural inequalities and policy decisions have a clear detrimental effect on the health of sections of the population. This thesis contributes to a body of evidence that should enable them to do so.

Appendix A: MVLS ethics approval



University of Glasgow | College of Medical,
Veterinary & Life Sciences

19th December 2014

Dear Professor O'Donnell

MVLS College Ethics Committee

Project Title: Exploring the access and use of preventive healthcare services for migrants from Sub Saharan Africa

Project No: 200140045

The College Ethics Committee has reviewed your application and has agreed that there is no objection on ethical grounds to the proposed study. It is happy therefore to approve the project, subject to the following conditions:

- Project end date: **30th April 2017**
- The research should be carried out only on the sites, and/or with the groups defined in the application.
- Any proposed changes in the protocol should be submitted for reassessment, except when it is necessary to change the protocol to eliminate hazard to the subjects or where the change involves only the administrative aspects of the project. The Ethics Committee should be informed of any such changes.
- If the study does not start within three years of the date of this letter, the project should be resubmitted.
- You should submit a short end of study report to the Ethics Committee within 3 months of completion.

Yours sincerely

Dr Dorothy McKeegan, College Ethics Officer

Dr Dorothy McKeegan
Senior Lecturer

R303 Level 3

Institute of Biodiversity Animal Health and Comparative Medicine

Jarrett Building

Glasgow G61 1QH Tel: 0141 330 5712

E-mail: Dorothy.McKeegan@glasgow.ac.uk

Appendix B: NHS GG&C R&D approval



R&D Management Office
Western Infirmary
Tennent Institute
1st Floor 38 Church Street
Glasgow, G11 6NT,

Administrator: Mrs Lorraine Reid
Telephone Number: 0141 211 1743
E-Mail: lorraine.Reid2@ggc.scot.nhs.uk
Website: www.nhsggc.org.uk/r&d

29 January 2015

Ms Anna R Isaacs
PhD Student
University of Glasgow
1 Horselethill Rd
Glasgow
G12 9LX

NHS GG&C Board Approval

Dear Ms Isaacs

Study Title: Exploring the provision and use of preventive health care services for migrants from Sub Saharan Africa in Glasgow

Chief Investigator: Ms Anna R Isaacs

Sponsor: NHS GG&C Health Board

R&D reference: GN14DI552

REC reference: N/A

Protocol no: Not Versioned dated Oct 2014

I am pleased to confirm that Greater Glasgow & Clyde Health Board is now able to grant **Approval** for the above study.

Conditions of Approval

1. **For Clinical Trials** as defined by the Medicines for Human Use Clinical Trial Regulations, 2004
 - a. During the life span of the study GGHB requires the following information relating to this site
 - i. Notification of any potential serious breaches.
 - ii. Notification of any regulatory inspections.

It is your responsibility to ensure that all staff involved in the study at this site have the appropriate GCP training according to the GGHB GCP policy (www.nhsggc.org.uk/content/default.asp?page=s1411), evidence of such training to be filed in the site file.

2. **For all studies** the following information is required during their lifespan.
 - a. Recruitment Numbers on a monthly basis
 - b. Any change of staff named on the original SSI form
 - c. Any amendments – Substantial or Non Substantial
 - d. Notification of Trial/study end including final recruitment figures
 - e. Final Report & Copies of Publications/Abstracts

Please add this approval to your study file as this letter may be subject to audit and monitoring.

Your personal information will be held on a secure national web-based NHS database.

I wish you every success with this research study

Yours sincerely



Mrs Lorraine Reid
Senior Research Administrator

CC: Emma-Jane Gault, Sponsor Representative, Glasgow
Dr Sara Macdonald, Academic Supervisor1, University of Glasgow
Dr Nicola Burns, Academic Supervisor2, University of Glasgow
Catherine O'Donnell, Academic Supervisor3, University of Glasgow

Appendix C: NHS GG&C letter of access



Senior Research Administrator: Lorraine Reid
 Telephone Number: 0141 211 1743
 E-Mail: Lorraine.Reid@ggc.scot.nhs.uk
 Website: www.nhsggc.org.uk/r&d

R&D Management Office
 Western Infirmary
 Tennent Building
 1st Floor, 38 Church Street
 Glasgow, G11 6NT.

29 January 2015

Ms Anna R Isaacs
 PhD Student
 University of Glasgow
 1 Horselethill Rd
 Glasgow
 G12 9LX

Dear Ms Isaacs

Letter of Access for Research

This letter confirms your right of access to conduct research through **NHS Greater Glasgow and Clyde** for the purpose and on the terms and conditions set out below. This right of access commences on **29th Jan 2015** and ends on **1st Sept 2015** unless terminated earlier in accordance with the clauses below.

You have a right of access to conduct such research as confirmed in writing in the letter of permission for research from this NHS organisation. Please note that you cannot start the research until the Principal Investigator for the research project has received a letter from us giving permission to conduct the project.

The information supplied about your role in research at **NHS Greater Glasgow and Clyde** has been reviewed and you do not require an honorary research contract with this NHS organisation. We are satisfied that such pre-engagement checks as we consider necessary have been carried out.

You are considered to be a legal visitor to **NHS Greater Glasgow and Clyde** premises. You are not entitled to any form of payment or access to other benefits provided by this NHS organisation to employees and this letter does not give rise to any other relationship between you and this NHS organisation, in particular that of an employee.

While undertaking research through **NHS Greater Glasgow and Clyde**, you will remain accountable to your employer **the University of Glasgow** but you are required to follow the reasonable instructions of **Dr Linda De Caestecker** in this NHS organisation or those given on her/his behalf in relation to the terms of this right of access.

Where any third party claim is made, whether or not legal proceedings are issued, arising out of or in connection with your right of access, you are required to co-operate fully with any investigation by this NHS organisation in connection with any such claim and to give all such assistance as may reasonably be required regarding the conduct of any legal proceedings.

You must act in accordance with **NHS Greater Glasgow and Clyde** policies and procedures, which are available to you upon request, and the Research Governance Framework.

You are required to co-operate with **NHS Greater Glasgow and Clyde** in discharging its duties under the Health and Safety at Work etc Act 1974 and other health and safety legislation and to take reasonable care for the health and safety of yourself and others while on **NHS Greater Glasgow and Clyde** premises. You must observe the same standards of care and propriety in dealing with patients, staff, visitors, equipment

and premises as is expected of any other contract holder and you must act appropriately, responsibly and professionally at all times.

If you have a physical or mental health condition or disability which may affect your research role and which might require special adjustments to your role, if you have not already done so, you must notify your employer and the health board's HR department prior to commencing your research role at the Health board.

You are required to ensure that all information regarding patients or staff remains secure and *strictly confidential* at all times. You must ensure that you understand and comply with the requirements of the NHS Confidentiality Code of Practice (<http://www.dh.gov.uk/assetRoot/04/06/92/54/04069254.pdf>) and the Data Protection Act 1998. Furthermore you should be aware that under the Act, unauthorised disclosure of information is an offence and such disclosures may lead to prosecution.

You should ensure that, where you are issued with an identity or security card, a bleep number, email or library account, keys or protective clothing, these are returned upon termination of this arrangement. Please also ensure that while on the premises you wear your ID badge at all times, or are able to prove your identity if challenged. Please note that this NHS organisation accepts no responsibility for damage to or loss of personal property.

We may terminate your right to attend at any time either by giving seven days' written notice to you or immediately without any notice if you are in breach of any of the terms or conditions described in this letter or if you commit any act that we reasonably consider to amount to serious misconduct or to be disruptive and/or prejudicial to the interests and/or business of this NHS organisation or if you are convicted of any criminal offence. You must not undertake regulated activity if you are barred from such work. If you are barred from working with adults or children this letter of access is immediately terminated. Your employer will immediately withdraw you from undertaking this or any other regulated activity and you **MUST** stop undertaking any regulated activity immediately.

Your substantive employer is responsible for your conduct during this research project and may in the circumstances described above instigate disciplinary action against you.

NHS Greater Glasgow and Clyde will not indemnify you against any liability incurred as a result of any breach of confidentiality or breach of the Data Protection Act 1998. Any breach of the Data Protection Act 1998 may result in legal action against you and/or your substantive employer.

If your current role or involvement in research changes, or any of the information provided in your Research Passport changes, you must inform your employer through their normal procedures. You must also inform your nominated manager in this NHS organisation.

Yours sincerely



Lorraine Reid
Senior Research Administrator

cc: Dr Linda De Caestecker, NHS GG&C.

Appendix D: Recruitment Poster

Invitation to take part in research about African migrants' access to healthcare services

Are you an African migrant living in Glasgow?



My name is Anna and I am a PhD student at the University of Glasgow. I would like to interview you about your healthcare experiences in Glasgow.



I would like to know what **you** think is important about living in Glasgow and about your health here. Your views are very important!

All information will be kept strictly confidential

If you are interested in taking part please contact Anna Isaacs directly by email a.isaacs.1@research.gla.ac.uk or telephone 0141 330 7138 OR you can give your name and contact details to the worker/volunteer who gave you this flier and they will arrange for Anna to contact you with more information
Thank you.



University
of Glasgow

Recruitment poster Version 3: 18/12/14 [Type text]



Appendix E: Interview invitation letters

1. Public health professionals



29/09/2015

Anna Isaacs
 General Practice and Primary Care
 Institute of Health and Wellbeing
 University of Glasgow
 1 Horselethill Road
 G12 9LX

R.E: Exploring access to and use of preventive healthcare services by African migrants

Dear

I am a doctoral student in General Practice and Primary care, Institute of Health and Wellbeing. I am writing to request your help with the above research study which I am undertaking as part of my PhD in General Practice and Primary Care. This study has been reviewed and approved by the University of Glasgow College of MVLS ethics committee on 19/12/2014. It was also reviewed and approved by NHS R&D on 15/01/2015.

This study aims to explore issues around the access and use of (preventive) health care services for African migrants in particular, but also migrant groups more generally. Within this I have a particular focus on the prevention of type II diabetes and cardiovascular disease. I hope to discuss the barriers and facilitators to developing and providing preventive care services for migrant communities. I am keen to gain the perspectives of public health consultants whose remits include migrant health, health inequalities and/ or preventive care services.

I would be delighted to interview you and/ or a relevant colleague for this research. If you were interested in taking part I would interview you about your experiences related to the development and provision of preventive healthcare services for migrants, as well as the general healthcare needs of this population. I can be flexible around time commitments and will be happy to travel to your workplace to conduct the interviews. Interviews can be conducted individually, or in a small focus group depending on preference.

With permission all interviews will be audio-recorded. Any information collected will be anonymised. Once the research is complete your practice would be invited to attend a Knowledge Exchange Event where the results of this study will be presented with time for discussion afterwards.

An information sheet with further details about the study is enclosed. I would be delighted to discuss the study details further either by phone or by visiting your workplace.

If you are interested in taking part in this study or would like further information please contact Anna Isaacs on 0141 330 7138, email a.isaacs.1@research.gla.ac.uk. I look forward to hearing from you.

Thank you

Yours sincerely

Anna Isaacs

EXPRESSION OF INTEREST REPLY SLIP:

Study Title: Exploring access to and use of preventive healthcare services for migrants from Sub Saharan Africa

If you are willing to consider taking part in the study please complete this form and return in the prepaid addressed envelope or if you would prefer please contact Anna Isaacs directly on 0141 3307138 or by email a.isaacs.1@research.gla.ac.uk.

Tel number

Best times to call.....

Signature

Name (print)

Date

2. Primary care professionals



Date

Anna Isaacs
 General Practice and Primary Care
 Institute of Health and Wellbeing
 University of Glasgow
 1 Horselethill Road
 G12 9LX

R.E: Exploring access to and use of preventive healthcare services by African migrants

Dear

I am a doctoral student in General Practice and Primary care, Institute of Health and Wellbeing. I am writing to request your help with the above research study which I am undertaking as part of my PhD in General Practice and Primary Care. This study has been reviewed and approved by the University of Glasgow College of MVLS ethics committee on *insert date*. It was also reviewed and approved by NHS R&D on 15/01/2015.

This study aims to explore issues around the access and use of (preventive) health care services for African migrants in particular, but also migrant groups more generally. I hope to discuss the barriers and facilitators to providing preventive care for migrant communities. Primary care practices play an important role in the provision of care for migrants and in the prevention and management of conditions such as CVD and type II diabetes. I am therefore interested in hearing the views of GPs, Practice Nurses and Receptionists about their experiences of providing health care for this population.

I am contacting surgeries based in areas that have notable migrant populations and are therefore well placed to share experiences of providing primary health care for this population.

Ideally I would like to recruit a GP, a Practice Nurse and a Receptionist from your practice to take part in this study. However, if not all of these health care professionals are willing to take part I would be very happy to recruit whoever from within these groups would be interested. If you were interested in taking part I would interview you about your experiences of providing care for migrants generally as well as in relation to the prevention and management of chronic diseases. I can be flexible around time commitments and will be happy to travel to the practice to conduct the interviews. Interviews can be conducted individually, or in a small focus group depending on preference.

With permission all interviews will be audio-recorded. Any information collected will be anonymised. Once the research is complete your practice would be invited to attend a Knowledge Exchange Event where the results of this study will be presented with time for discussion afterwards.

An information sheet with further details about the study is enclosed. I would be delighted to discuss the study details further either by phone or by visiting the practice.

If you are interested in taking part in this study or would like further information please contact Anna Isaacs on 0141 330 7138, email a.isaacs.1@research.gla.ac.uk, or return the attached reply slip in the envelope provided.

I look forward to hearing from you.

Thank you

Yours sincerely

Anna Isaacs

Doctoral Student

EXPRESSION OF INTEREST REPLY SLIP:

Study Title: Exploring access to and use of preventive healthcare services for migrants from Sub Saharan Africa

If you are willing to consider taking part in the study please complete this form and return in the prepaid addressed envelope or if you would prefer please contact Anna Isaacs directly on 0141 3307138 or by email a.isaacs.1@research.gla.ac.uk.

Tel number

Best times to call.....

Signature

Name (print)

Date

Appendix F: Participant information sheets

1. Ketso



Participant Information Sheet: Focus Groups

Study title:

Exploring the provision and use of preventive healthcare services for cardiovascular disease and type II diabetes by migrants from Sub Saharan Africa

Invitation:

I would like to invite you to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Please ask me if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

If you decide to take part you will be asked to sign a consent form to show that you have agreed to take part. You are free to withdraw at any time, without giving a reason.

What is the purpose of the study?

This study aims to understand perspectives on preventive healthcare and preventive healthcare services for African migrants, with a particular focus on the primary prevention of CVD and type II diabetes. It is important that all individuals in Glasgow benefit equally from health service provision, yet little is known about how African migrants feel about these services and about preventive healthcare more generally. To understand this more fully, I will be interviewing African migrants, primary care staff and public health professionals.

Why have I been chosen?

You have been chosen because you have moved to Glasgow from a country in African and are over 18 years old. We are interested in talking to you about your views on the health system and keeping healthy in Glasgow.

Do I have to take part?

Taking part is entirely voluntary. It is up to you to decide whether or not you wish to take part. Your decision to take part or not will have no impact on your involvement with any community groups or services.

What will happen to me if I take part?

If you choose to take part you will be invited to attend a group workshop at your community group. The workshop will use an interactive format to discuss the question “**Is Glasgow good for my health?**” I am interested in exploring the topics that you feel are most important, so the focus group will be very flexible. You will not have to talk about anything that makes you uncomfortable. The workshop will last around two hours. The workshop group will be recorded on an audio recorder and I may take some written notes. A research assistant may be present.

After the workshop, I may ask you if you are interested in taking part in further research, such as an individual interview. This is entirely voluntary. Taking part in the focus group does **not** mean you have to participate in an interview.

Will my participation in this research be confidential?

Your participation in this study, and everything you say to us, will be kept **entirely confidential**. Any information we keep will have your name and contact details removed and will be identified only by an ID number. Representatives of the study sponsor, NHS Greater Glasgow and Clyde, may look at your information to make sure that the study is being conducted correctly.

Following the workshop the contents of the recording will be transcribed either by Anna Isaacs or a University secretary. Your name will be removed from the written version of the workshop record and so it will be impossible to identify who you are from the written record. All written transcripts will be kept in securely locked filing cabinets in the Department of General Practice and Primary Care, University of Glasgow. All electronic information will be kept in password-protected files on the University of Glasgow server. Only the research team will have access to this information. The audio recordings will be destroyed at the end of the research. All other electronic files will be destroyed 10 years after the research has finished.

Written information from the workshop, including directed quotations, will be used in Anna Isaacs’ PhD thesis and to public articles in academic journals. However it will **not** be possible to identify you from this information.

What are the possible disadvantages of taking part?

If you decide to take part you will be talking in some detail about your experiences of healthcare and staying healthy in Glasgow. Some people may find some of the topics discussed difficult or upsetting. You are able to leave the workshop at any time, and you do not have to discuss anything you feel uncomfortable with.

What are the possible benefits of taking part?

Through this research you will be able to talk about your experiences of using health services and keeping healthy in Glasgow. You will be able to discuss what *you* think is important and what *you* think needs to be improved. This will be extremely helpful in helping us understand how we can best design health services to meet the needs of everyone in Glasgow.

What will happen to the results of the research study?

The results of the study will be published as part of Anna Isaacs' PhD thesis. The results will also be used to publish articles in academic journals and to present results at academic conferences. You will not be able to be identified from any of these publications. If you wish see any of these publications you are welcome to contact the research team.

I will also run a knowledge exchange event, where I will discuss the outcomes of the research. You will be notified of the timing of this event and invited to attend. It is up to you to decide whether you wish to attend.

Who is organising and funding the research?

The research is being organised and undertaken by the lead researcher, Anna Isaacs, as part of her higher degree (PhD) in General Practice and Primary Care at the University of Glasgow. It is funded through a Medical Research Council (MRC) doctoral training centre grant.

This study has been reviewed and approved by the University of Glasgow College of MVLS ethics committee on 19/12/2014. It was also reviewed and approved by NHS R&D on *insert date*.

Contact details:

If you have any questions speak to Anna Isaacs either in person when she attends your community group or using the following details:

Phone: 0141 330 7138

Email: a.isaacs.1@research.gla.ac.uk

Address: Anna Isaacs
General Practice and Primary Care
Institute of Health and Wellbeing
University of Glasgow
1 Horselethill Road
Glasgow G12 9LX

You may also contact Professor Catherine O'Donnell if you wish:

Phone: 0141 330 8329

Email: Kate.O'Donnell@glasgow.ac.uk

Address: Prof. Catherine O'Donnell
General Practice and Primary Care
Institute of Health and Wellbeing
University of Glasgow
1 Horselethill Road
Glasgow G12 9LX

Thank you for considering taking part in this research. Please feel free to discuss it with a relative or friend.

2. ASR interviews



Participant Information Sheet

Study title:

Exploring the provision and use of preventive healthcare services for cardiovascular disease and type II diabetes by migrants from Sub Saharan Africa.

Invitation:

I would like to invite you to take part in a research study. Before you decide whether to take part it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Please ask me if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

If you decide to take part you will be asked to sign a consent form to show that you have agreed to take part. You are free to withdraw at any time, without giving a reason.

What is the purpose of the study?

This study aims to understand perspectives on preventive healthcare and preventive healthcare services for African migrants, with a particular focus on the primary prevention of CVD and type II diabetes. It is important that all individuals in Glasgow benefit equally from health service provision, yet little is known about how African migrants feel about these services and about preventive healthcare more generally. To understand this more fully, I will be interviewing African migrants, primary care staff and public health professionals.

Why have I been chosen?

You have been chosen because you have moved to Glasgow from a country in Africa and are over 18 years old. We are interested in talking to you about your views on the health system in Glasgow and keeping healthy in Glasgow.

Do I have to take part?

Taking part is entirely voluntary. It is up to you to decide whether or not you wish to take part. Your decision to take part or not will have no impact on your involvement with any community groups or services.

What will happen to me if I take part?

If you choose to take part you will be invited to participate in an interview. There are three different types of interviews that you can participate in and it is up to you to decide which you prefer. All interviews will last between one and two hours and you are welcome to participate in more than one interview if you wish to. If you are willing to be recorded, the interviews will be recorded on an audio recorder. I may also take some written notes.

The three types of interview you can participate in are:

1. A **sit-down** interview: We will arrange a convenient time and location for you to take part in an interview. I will ask you about your experiences of staying healthy, accessing healthcare services and preventive healthcare services, as well as about your life in Glasgow more generally. I want to know what is important to you and so the interview will be very flexible.
2. A **“go-along”** interview: I would like you to take me on a walk around your local neighbourhood or an area you visit often. I would like you to show me what is good about the neighbourhood and what is bad about it. I will ask you some questions about your experiences of staying healthy, accessing healthcare services and about your life in Glasgow more generally. However, the interview will be led by you and what you think is important.
3. A **photo-sharing** interview: I will bring you a disposable camera and will ask you to take photos of things that are good for your health and bad for your health (e.g., in your home or your neighbourhood). After two weeks you will return the camera to me so I can develop the photos. Two weeks later we will arrange a convenient time and location for you to take part in an interview. We will talk about the photos that you took. I will also ask you about your experiences of staying healthy, accessing healthcare services and preventive healthcare services, as well as about your life in Glasgow more generally. I want to know what is important to you and so the interview will be very flexible.

At the end of the interview, I would like to give you a £15 voucher to thank you for your time taking part in this study.

Will my participation in this research be confidential?

Your participation in this study, and everything you say to us, will be kept **entirely confidential**. Any information we keep will have your name and contact details removed and will be identified only by an ID number. Representatives of the study sponsor, NHS Greater Glasgow and Clyde, may look at your information to make sure that the study is being conducted correctly.

Following the interview the contents of the recording will be transcribed (written out) either by Anna Isaacs or a University secretary. Your name will be removed from the written version of the interview record and so it will be impossible to identify who you

are from the written record. All written transcripts will be kept in securely locked filing cabinets in the Department of General Practice and Primary Care, University of Glasgow. All electronic information will be kept in password-protected files on the University of Glasgow server. Only the research team will have access to this information. The audio recordings will be destroyed at the end of the research. All other electronic files will be destroyed 10 years after the research has finished.

Written information from the interview, including direct quotations, will be used in my PhD thesis and to public articles in academic journals. However it will **not** be possible to identify you from this information.

What are the possible disadvantages of taking part?

If you decide to take part you will be talking in some detail about your experiences of healthcare and staying healthy in Glasgow. Some people may find some of the topics discussed difficult or upsetting. You are able to stop the interview at any time, and you do not have to discuss anything you feel uncomfortable with.

What are the possible benefits of taking part?

Through this research you will be able to talk about your experiences of using health services and keeping healthy in Glasgow. You will be able to discuss what *you* think is important and what *you* think needs to be improved. This will be extremely helpful in helping us understand how we can best design health services to meet the needs of everyone in Glasgow.

What will happen to the results of the research study?

The results of the study will be published as part of my PhD thesis. The results will also be used to publish articles in academic journals and to present results at academic conferences. You will not be able to be identified from any of these publications. If you wish see any of these publications you are welcome to contact the research team.

I will also run a knowledge exchange event, where I will discuss the outcomes of the research. You will be notified of the timing of this event and invited to attend. It is up to you to decide whether you wish to attend.

Who is organising and funding the research?

The research is being organised and undertaken by the lead researcher, Anna Isaacs, as part of her higher degree (PhD) in General Practice and Primary Care at the University of Glasgow. It is funded through a Medical Research Council (MRC) doctoral training centre grant.

This study has been reviewed and approved by the University of Glasgow College of MVLS ethics committee on 19/12/2014. It was also reviewed and approved by NHS R&D on *insert date*.

Contact details:

If you have any questions speak to Anna Isaacs either in person when she attends your community group or using the following details:

Phone: 0141 330 7138

Email: a.isaacs.1@research.gla.ac.uk

Address: Anna Isaacs
General Practice and Primary Care
Institute of Health and Wellbeing
University of Glasgow
1 Horselethill Road
Glasgow G12 9LX

You may also contact Professor Catherine O'Donnell if you wish:

Phone: 0141 330 8329

Email: Kate.O'Donnell@glasgow.ac.uk

Address: Prof. Catherine O'Donnell
General Practice and Primary Care
Institute of Health and Wellbeing
University of Glasgow
1 Horselethill Road
Glasgow G12 9LX

Thank you for considering taking part in this research. Please feel free to discuss it with a relative or friend.

3. Public health professionals



Participant Information Sheet

Study title: Exploring the provision and use of preventive healthcare services for cardiovascular disease and type II diabetes by migrants from Sub Saharan Africa.

I would like to invite you to take part in a research study. Before you decide whether to participate it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Please ask me if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

If you decide to participate you will be asked to sign a consent form to show that you have agreed to take part. You are free to withdraw at any time, without giving a reason.

What is the purpose of the study?

This study aims to understand perspectives on preventive healthcare and preventive healthcare services for African migrants, with a particular focus on the primary prevention of CVD and type II diabetes. It is important that all individuals in Glasgow benefit equally from health service provision, yet little is known about how African migrants feel about these services and about preventive healthcare more generally. To understand this more fully, I will be interviewing African migrants, primary care staff and public health professionals.

Why have I been chosen?

You have been chosen because you are involved in public health service provision in Glasgow and have a remit that includes migrant and ethnic minority health, preventive healthcare or health inequalities.

Do I have to take part?

Taking part is entirely voluntary. It is up to you to decide whether or not you wish to take part.

What will happen to me if I take part?

If you choose to take part we will arrange an interview of approximately one hour at a time and location that is convenient for you. The interview will be loosely structured around your thoughts on the provision of preventive healthcare services, migrant health and African health in Glasgow. I am interested in exploring the topics that you feel are

most important, so the interview will be very flexible. At no point will you be obliged to talk about issues with which you do not feel comfortable. The interview will be recorded on an audio recorder and I may take some written notes.

Will my information be kept confidential?

Your participation in this study, and everything you say to us, will be kept **entirely confidential**. Any information we keep will have your name and contact details removed and will be identified only by an ID number. Representatives of the study sponsor, NHS Greater Glasgow and Clyde, may look at your information to make sure that the study is being conducted correctly

Following the interview the contents of the recording will be transcribed either by Anna Isaacs or a University secretary. Your name will be removed from the written version of the interview record and so it will be impossible to identify who you are from the written record. All written transcripts will be kept in securely locked filing cabinets in the Department of General Practice and Primary Care, University of Glasgow. All electronic information will be kept in password-protected files on the University of Glasgow server. Only the research team will have access to this information. The audio recordings will be destroyed at the end of the research. All other electronic files will be destroyed 10 years after the research has finished.

Written information from the interview, including directed quotations, will be used in Anna Isaacs' PhD thesis and to public articles in academic journals. However it will **not** be possible to identify you from this information.

What will happen to the results of the research study?

The results of the study will be published as part of Anna Isaacs' PhD thesis. The results will also be used to publish articles in academic journals and to present results at academic conferences. You will not be able to be identified from any of these publications. If you wish see any of these publications you are welcome to contact the research team.

I will also run a knowledge exchange event, where I will discuss the outcomes of the research. You will be notified of the timing of this event and invited to attend. It is up to you to decide whether you wish to attend.

Who is organising and funding the research?

The research is being organised and undertaken by the lead researcher, Anna Isaacs, as part of her higher degree (PhD) in General Practice and Primary Care at the University of Glasgow. It is funded through a Medical Research Council (MRC) doctoral training centre grant.

This study has been reviewed and approved by the University of Glasgow College of MVLS ethics committee on 19/12/2014. It was also reviewed and approved by NHS R&D on 29/01/2015.

Contact information:

Phone: 0141 330 7138

Email: a.isaacs.1@research.gla.ac.uk

Address: Anna Isaacs
General Practice and Primary Care
Institute of Health and Wellbeing
University of Glasgow
1 Horselethill Road
Glasgow G12 9LX

You may also contact Professor Catherine O'Donnell if you wish:

Phone: 0141 330 8329

Email: Kate.O'Donnell@glasgow.ac.uk

Address: Prof. Catherine O'Donnell
General Practice and Primary Care
Institute of Health and Wellbeing
University of Glasgow
1 Horselethill Road
Glasgow G12 9LX

Thank you for considering taking part in this research.

4. Primary care professionals



Participant Information Sheet

Study title: Exploring the provision and use of preventive healthcare services for cardiovascular disease and type II diabetes by migrants from Sub Saharan Africa.

I would like to invite you to take part in a research study. Before you decide whether to participate, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Please ask me if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

If you decide to participate you will be asked to sign a consent form to show that you have agreed to take part. You are free to withdraw at any time, without giving a reason.

What is the purpose of the study?

This study aims to understand perspectives on preventive healthcare and preventive healthcare services for African migrants, with a particular focus on the primary prevention of CVD and type II diabetes. It is important that all individuals in Glasgow benefit equally from health service provision, yet little is known about how African migrants feel about these services and about preventive healthcare more generally. To understand this more fully, I will be interviewing African migrants, primary care staff and public health professionals.

Why have I been chosen?

You have been chosen because you are a primary care professional working in an area with a large number of migrants.

Do I have to take part?

Taking part is entirely voluntary. It is up to you to decide whether or not you wish to take part.

What will happen to me if I take part?

If you choose to take part we will arrange an interview of approximately one hour at a time and location that is convenient for you. The interview will be loosely structured around your thoughts on the provision of preventive healthcare services and migrant health in Glasgow. I am interested in exploring the topics that you feel are most important, so the interview will be very flexible. At no point will you be obliged to talk about issues with which you do not feel comfortable. The interview will be recorded on an audio recorder and I may take some written notes.

Will my information be kept confidential?

Your participation in this study, and everything you say to us, will be kept **entirely confidential**. Any information we keep will have your name and contact details removed and will be identified only by an ID number. Representatives of the study sponsor, NHS Greater Glasgow and Clyde, may look at your information to make sure that the study is being conducted correctly.

Following the interview the contents of the recording will be transcribed either by Anna Isaacs or a University secretary. Your name will be removed from the written version of the interview record and so it will be impossible to identify who you are from the written record. All written transcripts will be kept in securely locked filing cabinets in the Department of General Practice and Primary Care, University of Glasgow. All electronic information will be kept in password-protected files on the University of Glasgow server. Only the research team will have access to this information. The audio recordings will be destroyed at the end of the research. All other electronic files will be destroyed 10 years after the research has finished.

Written information from the interview, including directed quotations, will be used in Anna Isaacs' PhD thesis and to public articles in academic journals. However it will **not** be possible to identify you from this information.

What will happen to the results of the research study?

The results of the study will be published as part of Anna Isaacs' PhD thesis. The results will also be used to publish articles in academic journals and to present results at academic conferences. You will not be able to be identified from any of these publications. If you wish see any of these publications you are welcome to contact the research team.

I will also run a knowledge exchange event, where I will discuss the outcomes of the research. You will be notified of the timing of this event and invited to attend. It is up to you to decide whether you wish to attend.

Who is organising and funding the research?

The research is being organised and undertaken by the lead researcher, Anna Isaacs, as part of her higher degree (PhD) in General Practice and Primary Care at the University of Glasgow. It is funded through a Medical Research Council (MRC) doctoral training centre grant.

This study has been reviewed and approved by the University of Glasgow University of Glasgow College of MVLS ethics committee on 19/12/2014. It was also reviewed and approved by NHS R&D on 15/01/2015.

Contact information:

Phone: 0141 330 7138

Email: a.isaacs.1@research.gla.ac.uk

Address: Anna Isaacs
General Practice and Primary Care
Institute of Health and Wellbeing
University of Glasgow
1 Horselethill Road
Glasgow G12 9LX

You may also contact Professor Catherine O'Donnell if you wish:

Phone: 0141 330 8329

Email: Kate.O'Donnell@glasgow.ac.uk

Address: Prof. Catherine O'Donnell
General Practice and Primary Care
Institute of Health and Wellbeing
University of Glasgow
1 Horselethill Road
Glasgow G12 9LX

Thank you for considering taking part in this research.

Appendix G: Consent form – Ketso, ASR, public health, primary care interviews



CONSENT FORM

Title of Study: Exploring the provision and use of preventive healthcare services for cardiovascular disease by migrants from Sub Saharan Africa in Glasgow

Name of Researcher: Anna Isaacs MSc, Doctoral Candidate in General Practice and Primary Care

1. I confirm that I have read and understand the information sheet dated 3rd Nov 2014 for the above study and have had the opportunity to ask questions.
2. I confirm that I have had sufficient time to consider whether or not I want to be included in the study.
3. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my legal rights being affected.
4. I understand that the interview will be recorded on a digital voice recorder and that this recording will be deleted at the end of the research
5. I understand that my information may be looked at by representatives of the study Sponsor, NHS GG&C, for audit purposes
6. I agree to take part in the above study.

Name of participant

Date

Signature

Researcher

Date

Signature

Comments or concerns during the study:

If you have any comments or concerns you may discuss these with the researcher. Please contact Anna Isaacs: a.isaacs.1@research.gla.ac.uk or 01413307138

Appendix H: Topic guides

1. Ketso

Ketso focus group topic guide

A Ketso kit contains four different colours of leaves, which are used to discuss various aspects of a question or topic, together with branches, which are used to group or link the leaves together. All Ideas are stuck on to a large piece of felt.

The workshop will be structured around the question:

“Is Glasgow good for my health”

The coloured leaves will represent different aspects of this question:

Brown: what influences my health in Glasgow?

Green: what is good about Glasgow in terms of my health?

Grey: what is bad about Glasgow in terms of my health?

Yellow: what improvements could be made?

Before the workshop starts I will stick some broader themes (e.g., the weather) down as branches on the felt mat, in case it is necessary to help spark conversation. However I will start the workshop with the mats folded over so that participants can come up with their own ideas first.

I will first ask participants to go around and say their name and where they are from.

Three or four brown leaves will be distributed to each participant. I will ask them to write down, or draw their thoughts on the leaves in terms of what influences their health in Glasgow. Around five minutes will be allocated for this. This section of the workshop is done in silence so that participants are able to focus on the question and those who are less vocal are also able to make a contribution.

After five minutes the felt mat is opened up revealing a few themes in the form of branches. Participants will be invited to stick their leaves on the relevant branches or create new branches if their theme isn't covered. Around ten minutes is allocated for this process and for a discussion of ideas.

The same process repeats with the other leaves until a large mind map has been created.

2. ASR sit-down interview

Migrant sit-down interview topic guide

Please note: interview is semi-structured so will vary according to the interests, and priorities of the participant. This topic guide describes the main areas to be covered and examples of questions that may be asked.

Life in Glasgow:

What are the good things about life in Glasgow?

What are the bad things?

What about the neighbourhood you live in?

What is good?

What is bad?

Is Glasgow good or bad for migrants?

How does it compare to your home country?

Health in Glasgow:

What do you consider to be a healthy life?

Are you able to live a healthy life in Glasgow?

What is good from a health perspective?

What is bad from a health perspective?

How do these issues compare to your experience in your home country?

Keeping healthy:

What things are important to you in terms of keeping healthy (in broadest sense)?

Have the things that are important to you changed since moving to Glasgow?

If you are feeling unwell what do you do?

Who do you talk to about your health?

Health service use:

Do you feel health services meet your needs?

Have you ever had trouble accessing services?

Do you feel doctors/ nurses/ receptionists respond to your needs?

Do they understand what you want/ do you understand what they want/

What might they do differently?

CVD and diabetes:

What are your thoughts around diet/ exercise/ smoking/ obesity/ stress (key CVD risk factors)

Do perspectives on these topics differ from your home country?

Do you think about diseases such as CVD and diabetes?

Do you know anyone who has them? Do you worry about them?

What can you do to prevent getting them?

Do you find it easy to do these things?

Are there difficulties?

Prevention:

Did you have a Keepwell check up (if in age range)?

Why or why not?

If so, was it helpful?

Discourses around migrants:

What do you think about the ways that migrants are talked about a)in the media; b)by politicians?

Do you ever hear people saying negative things about migrants to you?

Do you think the health service is good o bad for migrants?

3. ASR 'go-along' interview

Migrant Go-along interview topic guide

Please note: Below provides a list of potential prompts and topics to be covered. However the interview will be guided to a large extent by the walk around the individual's neighbourhood/ area they frequent regularly and what they decide to focus on.

Starting the walk:

- Can you tell me about where we are going to walk today?
- How long have you lived in/ frequented this neighbourhood?

Prompts during the walk:

- What are the positive things about the neighbourhood?
- What are the negative things about the neighbourhood?
- What would you change?
- Is it easy to be 'healthy' here? Why? Why not?
- What does being healthy mean to you?
- How does this neighbourhood compare to where you have lived previously?
- What are the shops like?
- What are the public spaces like?
- How would you get to health services if you needed to?

General topics that may be addressed:

Life in Glasgow:

What are the good things about life in Glasgow?

What are the bad things?

What about the neighbourhood you live in?

What is good?

What is bad?

Is Glasgow good or bad for migrants?

How does it compare to your home country?

Health in Glasgow:

What do you consider to be a healthy life?

Are you able to live a healthy life in Glasgow?

What is good from a health perspective?

What is bad from a health perspective?

How do these issues compare to your experience in your home country?

Keeping healthy:

What things are important to you in terms of keeping healthy (in broadest sense)?

Have the things that are important to you changed since moving to Glasgow?

If you are feeling unwell what do you do?

Who do you talk to about your health?

Health service use:

Do you feel health services meet your needs?

Have you ever had trouble accessing services?

Do you feel doctors/ nurses/ receptionists respond to your needs?

Do they understand what you want/ do you understand what they want/

What might they do differently?

CVD and diabetes:

What are your thoughts around diet/ exercise/ smoking/ obesity/ stress (key CVD risk factors)

Do perspectives on these topics differ from your home country?

Do you think about diseases such as CVD and diabetes?

Do you know anyone who has them? Do you worry about them?

What can you do to prevent getting them?

Do you find it easy to do these things?

Are there difficulties?

Prevention:

Did you have a Keepwell check up (if in age range)?

Why or why not?

If so, was it helpful?

Discourses around migrants:

What do you think about the ways that migrants are talked about a)in the media; b)by politicians?

Do you ever hear people saying negative things about migrants to you?

Do you think the health service is good o bad for migrants?

4. Public health interviews

Interview topic guide for public health professionals:

Please note: interview is semi-structured so will vary according to the interests, priorities, and specific role of the participant. This topic guide describes the main areas to be covered and examples of questions that may be asked.

All questions about migrants will start generally and then focus in on migrants from Sub Saharan Africa.

General migrant health needs:

- Do migrants have specific needs?
- If yes: What are they?
 Why do they exist?
 How are these needs addressed?
 Are there approaches that have worked well/ not so well?
 Are there areas where improvements could be made?

Chronic disease risk:

(Prompt cards will epidemiological information about African migrants and CVD risk will be used).

- Are migrants particularly at risk of diabetes/ CVD/ other chronic diseases?
- If yes: What are they?
 Why is this the case?
 How should this risk be addressed?
 Are there approaches that have worked well/ not so well?
 Are there areas where improvements could be made?

Public health provision

- What are the main challenges in terms of developing preventive interventions for migrants?
- What is currently being done in terms of CVD and diabetes prevention?
- What is being done well? Why?
- What is being done badly? Why?
- Are there issues outwith the remit of PH? How might they be addressed?
- Should preventive interventions target different people differently?

Attitudes on migration:

(Prompt card with information on the new UK migration bill will be provided)

- Does government policy (e.g., new migration bill) towards/ rhetoric on migration have an impact on a) migrant health, b) healthcare provision and c) care seeking?
- Do media representations of migrants have an impact on a) migrant health, b) healthcare provision and c) care seeking?
- Do general attitudes towards migration have an impact on a) migrant health, b) healthcare provision and c) care seeking?
- Do you perceive there to be differences between Scotland and England? If so are they important in terms of migrant health?

5. Primary care interviews

Primary Care staff interviews: topic guide

Please note: interview is semi-structured so will vary according to the interests, priorities, and specific role of the participant. This topic guide describes the main areas to be covered and examples of questions that may be asked.

All questions about migrants will start generally and then focus in on migrants from Sub Saharan Africa.

Migrant patients:

- Do you care for many migrants?
- Are there many African migrants?

General migrant health needs:

- Do migrants have specific needs?
- If yes: What are they?
 Why do they exist?
 How are these needs addressed?
 Are there approaches that have worked well/ not so well?
 Are there areas where improvements could be made?

Chronic disease risk:

(Prompt cards will epidemiological information about African migrants and CVD risk will be used).

- Are migrants particularly at risk of diabetes/ CVD/ other chronic diseases?
- If yes: What are they?
 Why is this the case?
 How should this risk be addressed?
 Are there approaches that have worked well/ not so well?
 Are there areas where improvements could be made?

Care seeking:

- To what extent is there concordance or discordance between when/ how African migrants seek care and when/how they are expected to?

General communication in consultations:

- Have you ever had concerns about communication (both in terms of language and meaning)?
- What do you do in these situations?
- Have you used interpreters?
- What do you see as the role of the interpreter?
- Do you think your migrant patients generally have similar or different understandings to you during a consultation?
- Have there been times when there have been misunderstandings? Do you have any examples?
- Are there ever mismatches of expectations?
- If misunderstandings occur, how might you try to address them?

Disease specific (diabetes/ CVD) communication:

- Have you ever had concerns about communication (both in terms of language and meaning) when discussing the management of chronic diseases?
- What do you do in these situations?
- Do you think your migrant patients with chronic diseases have generally similar or different understandings to you about their illness?
- Have there been times when there have been misunderstandings? Do you have any examples?
- Are there ever mismatches of expectations?
- If misunderstandings occur, how might you try to address them?

Preventive care:

- How well do you feel preventive care has been delivered to vulnerable communities in the past (e.g., Keep Well)?
- What is the role of primary care staff in preventive care?
- What are the barriers to effective preventive care for migrant communities?
- What positive resources might there be?
- Do preventive services need to be tailored (e.g., for migrants, ethnic minorities, different socioeconomic groups)?

Attitudes on migration:

(Prompt card with information on the new UK migration bill will be provided)

- Does government policy (e.g., new migration bill) towards/ rhetoric on migration have an impact on a) migrant health, b) healthcare provision and c) care seeking?
- Do media representations of migrants have an impact on a) migrant health, b) healthcare provision and c) care seeking?
- Do general attitudes towards migration have an impact on a) migrant health, b) healthcare provision and c) care seeking?
- Do you perceive there to be differences between Scotland and England? If so are they important in terms of migrant health?

Appendix I: ASR data collection form



Data Collection Form for African participants

Thank you for your interest in taking part in this study entitled “Exploring Access to and use of preventive healthcare services for migrants from Sub Saharan African in Scotland”.

We would be grateful if you could complete the following questionnaire. This will provide us with some background information about yourself so that we can ensure that we have a spread of participants from different backgrounds included in the study.

The information you provide will be kept confidential because we will remove the page with your name and contact details on it. You will not be identifiable to anyone other than Anna Isaacs. If you ultimately do not take part the sheet will be destroyed. You do not have to answer any questions you feel uncomfortable with.

Questionnaire:

Are you?: Male or Female

How old are you?: 18–24 24--29 30-39 40-49 50-59 >60

What is your marital status?: Single/Married/Co-habiting/Divorced/ Widowed

At what level did you leave education?: None/Primary/Secondary/University/other

How old were you when you left education?:

What is your religion?:

How frequently do you attend a place of worship?

Daily/Weekly/ Monthly/Annually/Never

How old were you when you came to the UK?:

How many years have you spent in the U.K?:

What is your country of birth?:

Do you consider that in Africa you came from?: A city, a town or a rural village

What nationality do you consider yourself to be?:

What is your Immigration status?: Asylum seeker, Refugee, Student Visa, Other migrant

What was your job before you came to the UK?:

What is your current employment?:

Name:

Contact number/ email/person:

Appendix J: Literature review search terms

Databases searched:

SocIndex, Web of Science, Medline, Cinahl, Science Direct, and Google Scholar.

Search strings used:

To retrieve papers on NCD prevention:

Prevent AND (*migrant* OR refugee* OR “asylum seeker*”) AND (diabetes OR CHD OR CVD OR “cardiovascular disease” OR “chronic heart disease”)*

To retrieve papers on access to primary care:

*(*migrant* OR refugee* OR “asylum seeker*”) AND (primary AND “health care” OR healthcare)*

To retrieve papers on general health and wellbeing:

*(*migrant* OR refugee* OR “asylum seeker*”) AND (health OR wellbeing)*

*note: the literature review took a narrative form and was therefore not intended to be exhaustive.

Appendix K: Ketso session data

Each comment was written on a leaf and grouped under resources, surroundings, health system, lifestyle, or immigration experiences.

Resources

Important for health

Integrating

Have job or self employment to earn a living

Eating healthy food

Children's centres to help mothers

Having good accommodation

Have good food

Good

Free food and clothes

Going to the centres

Meeting new people

Food banks

Democracy

Free education and NHS

ESOL classes

Groups where we go for different activities

Free to give information

Many charitable organisations, clothes, food banks, funds

ESOL classes everywhere

More resources of any kind

Bad

Transport is expensive

You can't get the job you want

Most churches are now pubs

Low rates at work places

Transport is so expensive

So hard to make a change in government

Eating and drinking in the bus

Change

More nurseries

End homelessness

Good jobs to all people

Make higher rates at work places

More cleanliness to be done

Improve wages

Reduce fairs

Improve communication

More centres

Surroundings

Important for health

Cleanliness

Support services: politics, housing officers, health, education

Good

All religions are accepted

Friendly people
 Museums in Glasgow
 Learning English
 Lots of ethnic minority groups
 Friendly
 Friendly people and accommodating
 Rent is not expensive

Bad

Drug addicts
 Very dirty in other places
 Too cold for Africans
 Lots of drug intake
 Smoking and more drug addicts
 Weather very cold
 Drugs and too much drink
 Many on drugs
 Weather so cold
 The weather is too much cold
 Waste of resources in health and employment
 Many people are jobless and take too much alcohol
 Some are racist but some are good
 Alcohol and drugs- not good
 So places are so dirty
 Government not good

Change

To ban all drug addicts
 Street cleaning (poo) and general litter

Health system

Important for health

Accessible health services
 Free food and healthcare
 Good health care

Good

Free medication and education (x2)
 Health services so good
 Health centre so good
 In Glasgow good health centres
 Free Health Service

Bad

Language is different
 Language barriers

change

Lifestyle

Important for health

Diet
 Walking everyday
 Cooking and learning English
 Exercising
 Activity
 Socialisation
 Enough rest

Talking and laughing
Keeping yourself busy
Watching your diet
Balanced diet
Exercise
Eating fruit
Music

Good

Bad

Homeless people

Change

Encourage people to work
Be role models for children
Don't drink or take drugs under 18 so bad

Immigration experiences

Important for health

Good

In Glasgow home office give good house

Bad

Won't be acknowledged who you are
Public transport segregation
People pretend to love you but actually they don't

Change

Treat migrants the same
Allow people to go to university for asylum seekers' children
Give people jobs that suit their profession
Good NHS care to asylum seekers

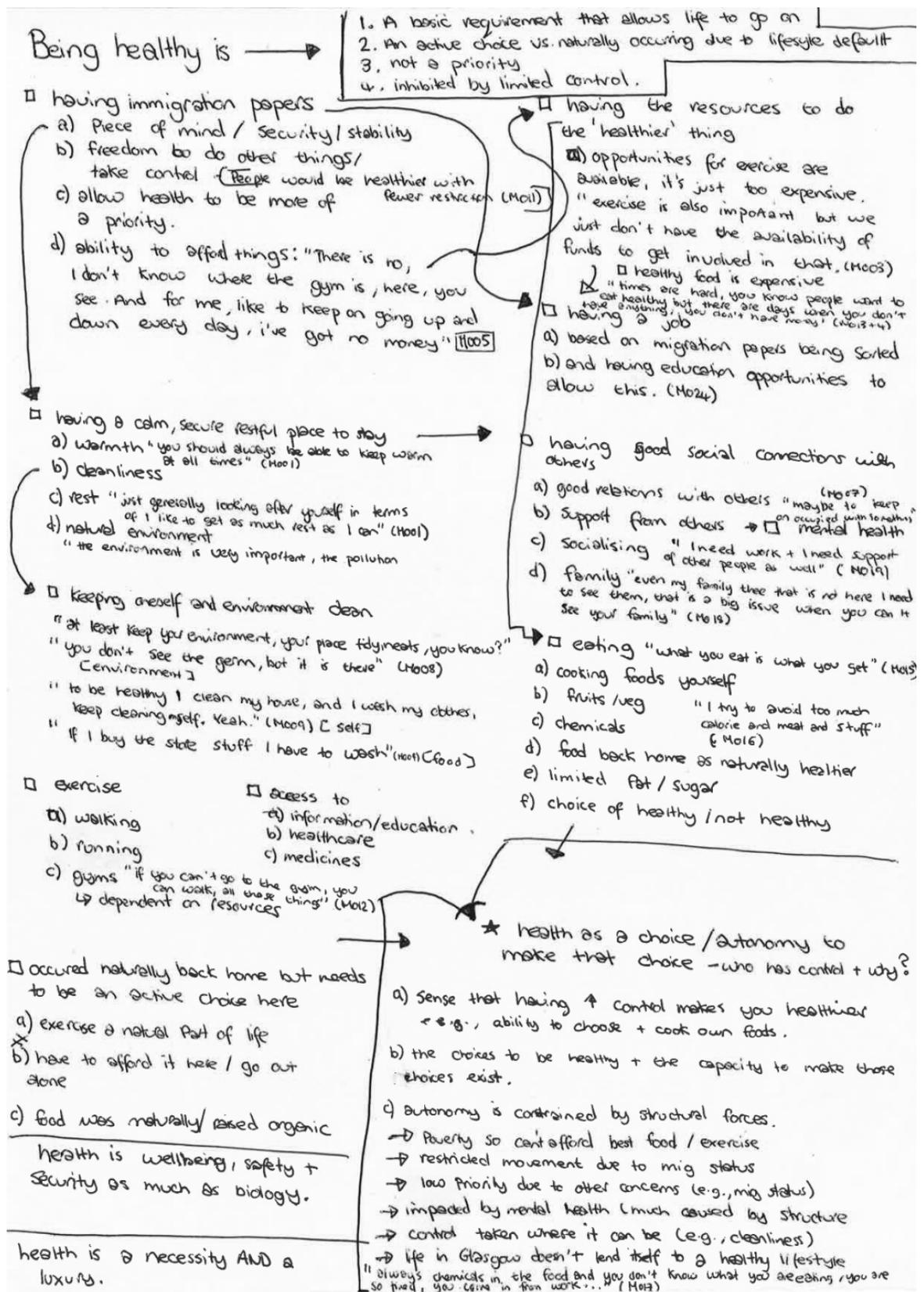
Appendix L: Coding Framework

- Culture (across all)
- Racism
 - Public attitudes
 - Professional attitudes
 - Overt racism
 - Subtle racism
 - Effect on self
 - Individual level vs. institutional racism
- Illness causation
 - Biological causes
 - Behavioural causes
 - Structural causes
 - Environmental causes
 - Cultural norms
 - Interaction of causes
- Prevention
 - Meaning of prevention
 - Methods of preventing
 - Changing perceptions
 - Barriers to prevention (behavioural and structural)
- Being healthy
 - Role of immigration status
 - Importance of your home surroundings
 - Being clean
 - Exercise
 - Natural vs intentional
 - Impact of resources
 - Social connections
 - food
- Language
 - Effect on ability to find work
 - Effect on ability to navigate services
 - Barrier to social integration
 - Communications with health professionals
 - Role of interpreters
 - Logistical challenges
- Visual and Physical environment
 - Negative aspects of physical environment
 - Positive aspects of physical environment
 - Impact of the environment on health
 - Buildings

- Weather
- Social Environment
 - Relations with locals in the area
 - Proximity to social connections
 - Proximity to resources
 - Proximity to transport
 - Neighbourhood activities/ behaviours
 - Feel of local area
- Home
 - Experiences of housing
 - What's important in a home
- Community
 - Glasgow 'community' as a whole
 - Effect of social networks
 - Community organisations
 - Volunteering
- Health perceptions - food
 - Role in promoting health
 - Food and cleanliness
 - Food in Africa
 - Food in Glasgow
 - Healthy foods
 - Unhealthy foods
 - Changes in diet related to moving
 - Barriers to eating healthy
- Health perceptions – exercise
 - Impact on health
 - Barriers to engagement
 - Exercise facilities
 - Site of community engagement
 - Changing perceptions on exercise
- Health Perceptions – other
 - Cleanliness
 - The body
 - Changing perceptions of health
- Health Services
 - Previous healthcare experiences
 - Getting used to a different system
 - Cultural factors affecting expectations/ interactions
 - Structural factors affecting engagement/ uptake
 - Management of asylum seeker care
 - GP care experiences
 - Secondary care experiences

- Language
 - expectations
- (non-health) services
 - Education
 - Information
 - Transport
 - Food banks
 - Accommodation
 - Organisations directed at refugees
 - Barriers to services access
- Political context – health
 - Scottish public health policy
 - Prevention policy
- Political context – migration
 - Medial environment around migration
 - Political rhetoric around migration
 - Public health attitudes toward migrants
 - Housing model for asylum seekers
 - Physical impact of policies on refugees
 - Psychological impacts of policies on refugees
 - Intersection of poverty and migration context
 - Political opinions of refugees
 - Difference between England and Scotland
- Migrant experience
 - Pre-arrival experiences
 - Asylum process
 - Limbo
 - Post decision experience
 - Loneliness
 - Being other
- Poverty
 - Effect on autonomy
 - Relationship with immigration status
 - Impact on mental health
 - Provisions for those in poverty
- Mental health
 - Impact on physical health
 - Health impact of previous trauma
 - Mental health impact of asylum process
 - Mental health impact of current life experiences
 - Cultural issues
 - Isolation
 - resilience

Appendix M: Example OSOP



List of References

- Abbott, P., Magin, P., Davison, J., and Hu, W. (2017). Medical Homelessness and candidacy: women transiting between prison and community healthcare, *International Journal for Equity in Health*, 16:130.
- Abbott, S., and Riga, M. (2007). Delivering services to the Bangladeshi community: the views of healthcare professionals in East London. *Public Health*, 121:935-941.
- Abubakar, I., Devakumar, D., Nyovani, M., Sammonds, P., Grace, N., Zimmerman, C., Aldridge, R.W., Clark, J., and Horton, R. (2016). UCL-Lancet Commission on Migration and Health, *The Lancet*, 388:1142.
- Aday, L.A. and Andersen, R. (1974). A framework for the study of access to medical care, *Health Services Research*, Fall Issue: 208-220.
- Africa Alba. (2016). AfricAlba: education, enterprise, sport. Available at: <http://www.africalba.org/>, (Accessed 01/06/2017).
- Ager, A., and Strang, A. (2004). The experience of integration: a qualitative study of refugee integration in the local communities of Pollokshaws and Islington, *Home Office Online Report 55/04*. [Online]. Available at: <http://subjects.library.manchester.ac.uk/referencing/referencing-harvard>, (Accessed 01/06/2017)
- Agudelo-Suárez, A.A., Gil González, D., Vives-Cases, C., Love, J.G., Wimpenny, P., and Ronda-Pérez, E. (2012). A metasynthesis of qualitative studies regarding opinions and perceptions about barriers and determinants of health services' accessibility in economic migrants, *BMC Health Services Research*, 12:461.
- Agyemang, C., Kunst, A. E., Bhopal, R., Anujo, K., Zaninotto, P., Nazroo, J., Nicolaou, M., Unwin, N., van Valkengoed, I., Redekop, W. K. and Stronks, K. (2011). Diabetes prevalence in populations of South Asian Indian and African Origins. *Epidemiology*, 22: 4, 563-567.
- Agyemang, C., Nicolaou, M., Boateng, L., Dijkshoorn, H., van de Born, B-J., and Stronks, K. (2012). Prevalence, awareness, treatment, and control of hypertension among Ghanaian

population in Amsterdam, the Netherlands: the GHAIA study, *European Journal of Preventive Cardiology*, 20:6, 938-946.

Agyemang, C., Meeks, K., Beune, E., Owusu-Dabo, E., Mockenhaupt, F.P., Addo, J., de Graft Aikins, A., Bahendeka, S., Danquah, I., Schulze, M.B., Spranger, J., Burr, T., Agyei-Baffour, P., Amoah, S.K., Galbete, C., Hennemn, P., Klipstein-Grobusch, K., Nicolaou, M., Adeyemo, A., van Straalen, J., Smeeth, L., and Stronks, K. (2016). Obesity and type 2 diabetes in sub-Saharan Africans – Is the burden in today’s Africa similar to African migrants in Europe? The RODAM study, *BMC Medicine*, 14:1, 166-178.

Ahmad, W. I. U. (1996). The trouble with culture. in Kelleher, D. and Hillier, S. (eds.) *Researching cultural differences in health*. London: Routledge.

Alexander, P., Budd, J., Sambale, P., and Watt, G. (2009). General Practitioners at the Deep End. Final report of a special meeting held on 16 September 2009 at Erskine Bridge Hotel. [Online]. Available at: http://www.gla.ac.uk/media/media_430491_en.pdf, (Accessed 23/09/17).

Allen, W. (2016). A decade of immigration in the British Press. Oxford: The Migration Observatory at the University of Oxford.

Allsop, J., Sigona, N., Phillimore, J. (2014). Poverty among refugees and asylum seekers in the UK, *IRiS Working Paper Series, 1, 1-46*.

Anderson, J. (2004). Talking whilst walking: a geographical archaeology of knowledge, *Area*, 36:3, 254-261.

Anderson, B., and Blinder, S. (2017). Briefing: Who counts as a migrant? Definitions and their consequences. Oxford: Migration Observatory at the University of Oxford.

Arcury, T. A., Skelly, A. H., Gesler, W. M., and Dougherty, M.C. (2004). Diabetes meanings among those without diabetes: explanatory models of immigrant Latinos in rural North Carolina, *Social Science and Medicine*, 59:2183-2193.

Aspinall, P and Watters, C. (2010). Refugees and asylum seekers: a review from an equality and human rights perspective. Equality and human rights research report 52.

- Atkinson, P. and Pugsley, L. (2005). Making sense of ethnography and medical education, *Medical Education*, 39:2, 228-234.
- Aung, N. C., Rechel, B, and Odermatt, P. (2010). Access to and utilisation of GP services among Burmese migrants in London: a cross-sectional descriptive study. *BMC Health Services Research*, 10:285-296.
- Ayotte, B. J., Hausmann, L. R. M., Whittle, J., and Kressin, R. R. (2012). The relationship between perceived discrimination and coronary artery obstruction, *American Heart Journal*, 163:677-683.
- Bader A, Musshauster D, Sahin F, Bezirkan H, Hochleitner M (2006) The Mosque Campaign: a cardiovascular prevention programme for female Turkish immigrants. *Wiener Klinische Wochenschrift*, 118: 7-8, 217-223.
- Basedow, J., and Doyle, L. (2016). England's forgotten refugees: out of the fire and into the frying pan. London: Refugee Council. [Online]. Available at: https://www.refugeecouncil.org.uk/assets/0003/7935/England_s_Forgotten_Refugees_final.pdf, (Accessed 10/09/17)
- Bandyopadhyay, M. (2011). Tackling complexities in understanding the social determinants of health: the contributions of ethnographic research. *BMC Public Health*, 11:5, 56-64.
- Bansal, N., Fischbacker, C. M., Bhopal, R. S., Brown, H., Steiner, M. F. C., and Capewell, S. (2013). Myocardial infarction incidence and survival by ethnic group: Scottish Health and Ethnicity Linkage retrospective cohort study, *BMJ Open*, 3:9, e003415.
- Bambra, C., Fox, D., and Scott-Samuel, A. (2005). Towards a politics of health, *Health Promotion International*, 20:2, 187-193.
- Baradaran, H. and Knill, Jones, R. (2004). Assessing the knowledge, attitudes and understanding of type 2 diabetes amongst ethnic groups, *Practical Diabetes International*, 21:4, 143-148.
- Barbour, R. S. (2003). The newfound credibility of qualitative research? Tales of technical essentialism and co-option. *Qualitative Health Research*. 13:7, 1019-1027.

- Baum, F. (2010). Overcoming barriers to improved research on the social determinants of health, *MEDICC Review*, 12:3, 36-38.
- Beauchamp, A., Peters, A., Tonkin, A. and Turrell, G. (2010). Best practice for prevention and treatment of cardiovascular disease through an equity lens: a review, *European Journal of Cardiovascular Prevention and Rehabilitation*, 17:5, 599-606.
- Becares, L., Nazroo, J., Jackson, J. and Heuvelman, H. (2012). 'Ethnic density effects on health and experienced racism among Caribbean people in the US and England: A cross-national comparison'. *Social Science and Medicine*, 75:2107-2115.
- Begg, H., and Gill, P. S. (2005). Views of general practitioners towards refugees and asylum seekers: an interview study, *Diversity in Health and Social Care*, 2:299-305.
- Beune, E. J. A. J., Haafkens, J. A., and Bindels, P. J. E. (2011). Barriers and enablers in the implementation of a provider based intervention to stimulate culturally appropriate hypertension education, *Patient Education and Counselling*, 82:74-80.
- Bhatia, R., and Wallace, P. (2007). Experiences of refugees and asylum seekers in general practice: a qualitative study, *BMC Family Practice*, 8:48.
- Bhopal, R. and Rankin, J. (2001). Understanding of heart disease and diabetes in a South Asian community: cross-sectional study testing the 'snowball' sample method, *Public Health*, 115:4, 253-260.
- Bhopal, R. (2004). Glossary of terms relating to ethnicity and race: for reflection and debate, *Journal of Epidemiology and Community Health*, 58:441-445.
- Bhopal, R. (2012). Research agenda for tackling inequalities related to migration and ethnicity in Europe. In D. Ingleby, A. Krasnik, V. Lorant and O. Razum (Eds.), *Cost Series on Health and Diversity Volume 1: Health Inequalities and Risk Factors among Migrants and Ethnic Minorities*. Antwerp-Apeldoorn: Garant Publishers.
- Birch, S. (1999). The 39 steps: the mystery of health inequalities in the UK, *Health Economics*, 8:301-308.

Blinder, S., and Allen, W. L. (2016). Briefing: UK public opinion towards immigration: overall attitudes and level of concern. Oxford: Migration Observatory at the University of Oxford.

Bourdieu, P. (1990). *The logic of Practice*. Cambridge: Polity Press

Bourdieu, P. and Wacquant, L. (2003). Symbolic violence in Bourgois, P. and Scheper Hughes, N. (eds.) *Violence in War and Peace*. UK: Wiley-Blackwell

Bowes, A., Ferguson, I., and Sim, D. (2009). Asylum policy and asylum experiences: interactions in a Scottish context, *Ethnic and Racial Studies*, 32:1,23-43.

Bradby, H. and Chandola, T. (2010). 'Inequalities and ethnicity: evidence and intervention' in J Douglas, S Earle, S Handsley, L Jones, C.E Lloyd and S Spurr (eds.) *A reader in promoting public health: challenge and controversy*. London: Sage.

Bradby, H. (2012). Race, ethnicity, and health: The costs and benefits of conceptualising racism and ethnicity, *Social Science and Medicine*, 75:955-958.

Bradby, H., Humphris, R., Newall, D., Phillimore, J. (2015). Public health aspects of migrant health: a review of the evidence on health status for refugees and asylum seekers in the European region, *Health Evidence Network Synthesis Report 44*, WHO.

Brassolotto, J., Raphael, D., and Baldeo, N. (2013). Epistemological barriers to addressing the social determinants of health among public health professionals in Ontario, Canada: a qualitative inquiry. *Critical Public Health*, 24:3, 321-336.

Brindle, P., May, M., Gill, P., Cappuccio, F., D'Agostino Sr, R., Fischbacher, C., and Ebrahim, S. (2006). Primary prevention of cardiovascular disease: a web-based risk score for seven British black and minority ethnic groups, *Heart*, 92:1595-1602.

British Heart Foundation. (2017). Risk Factors. Available at: <https://www.bhf.org.uk/heart-health/risk-factors>, (accessed 6:31pm).

Burka, M., Askins, K., Mulvey, G., Arnold, P., and McBride, J. (2017). Supporting asylum seekers: building capacity for service provision and policy advocacy. British Red Cross.

- Burnett, A., and Fassil, Y. (2001). Meeting the health needs of refugees and asylum seekers in the UK: An information and resource pack for health workers. London: Department of Health.
- Campos, P., Saguy, A., Ernsberger, P., Oliver, E., and Gaesser, G. (2006). The epidemiology of overweight and obesity: public health crisis or moral panic? *International Journal of Epidemiology*, 35: 55-60.
- Caplan, P. (1997). Approaches to the study of food, health and identity, in Caplan, P (ed.) *Food, Health and Identity*. London: Routledge.
- Carpiano, R. (2009). Come take a walk with me: the “go-along” interview as a novel method for studying the implications of place for health and well-being, *Health & Place*, 15:263-272.
- Carswell, K., Blackburn, P., and Barker, C. (2011). The relationship between trauma, post-migration problems, and the psychological well-being of refugees and asylum seekers, *International Journal of Social Psychiatry*, 57,2:107-119.
- Cartwright, E. (2011). Immigrant dreams: legal pathologies and structural vulnerabilities along the immigration continuum, *Medical Anthropology: Cross-Cultural Studies in Health and Illness*, 30,5:475-495.
- Castañeda, H. (2010). Im/migration and health: conceptual, methodological, and theoretical propositions for applied anthropology, *NAPA Bulletin*, 34:6-27.
- Castañeda, H. (2013). Structural vulnerability and access to medical care among migrant street-based male sex workers in Germany. *Social Science and Medicine*, 84:94-101.
- Castañeda, H., Holmes, S. M., Madrigal, D. S., DeTrinidad., Young, M-E., Beyeler, N., and Quesada, J. (2015). Immigration as a social determinant of health, *Annual Review of Public Health*, 36:375-392.
- Cattell, V., Dines, N., Gesler, W., and Curtis, C. (2008). Mingling, observing, and lingering: everyday public spaces and their implications for well-being and social relations, *Health and Place*, 14:544-561.

- Chase, L.E., Cleveland, J., Beatson, J., and Rousseau, C. (2017). The gap between entitlement and access to healthcare: an analysis of “candidacy” in the help-seeking trajectories of asylum seekers in Montreal, *Social Science and Medicine*, 182:52-59.
- Chauvin, P. (2013). Access to healthcare of excluded people in 14 cities of 7 European countries: Final report on social and medical data collected in 2012. Paris; Médecins du Monde/ Doctors of the World International Network.
- Cheng, I., Drillich, A., and Schattner, P. (2015). Refugee experiences of general practice in countries of resettlement: a literature review, *British Journal of General Practice*, e171-176
- Cooper, M., Harding, S., Mullen, K., and O'Donnell, K. (2012). ‘A chronic disease is a disease which keeps coming back...it is like the flu’: chronic disease risk perception and explanatory models among French- and Swahili-speaking African migrants, *Ethnicity and Health*, 17,6: 597-613.
- Correa-Velez, I., and Gifford, S. M. (2007). When the right to be counted doesn't count: the politics and challenges of researching the health of asylum seekers, *Critical Public Health*, 17, 3:273-281.
- Coupland, H., and Maher, L. (2010). Notions of injecting drug users' candidacy for hepatitis C treatment: conflicting provider, patient and public health perspectives, *Contemporary drug problems*, 37:549-573.
- Crenshaw, K. (1991). Mapping the margins: intersectionality, identity politics, and violence against women of colour, *Stanford Law Review*, 43:6, 1241-1299.
- Cristancho, S., Garces, D M., Peters, K E., and Mueller, B C. (2008). Listening to rural Hispanic immigrants in the Midwest: a community-based participatory assessment of major barriers to health care access and use. *Qualitative Health Research*. 18, 5:633-646.
- Critical Skills Appraisal Programme. (2013). Qualitative Research Checklist. Available at: http://media.wix.com/ugd/dded87_29c5b002d99342f788c6ac670e49f274.pdf, (Accessed 20/11/2015)

Cruickshank, J. (2012). Positioning positivism, critical realism and social constructionism in the health sciences: a philosophical orientation, *Nursing Enquiry*, 19, 1:71-82.

Cruz, E.V., and Higginbottom, G. (2013). The use of focused ethnography in nursing research. *Nurse Researcher*. 20:4, 36-43

Da Costa Lima, M., Jackson I., and Zimunya, M. (2016). African Health Project: Evidencing a model of working with HIV positive African people in Glasgow. [Online]. Available at: <http://www.waverleycare.org/wp-content/uploads/2017/01/African-Health-Project-Evidencing-A-model-of-working-Final-Report.pdf>, (Accessed 07/06/2017).

Dastjerdi, M., Olson, K., and Ogilvie, L. (2012). A study of immigrants' experiences of accessing Canadian health care services: a grounded theory, *International Journal for Equity in Health*, 11:55-69.

Dauvrin, M., Lorant, V., Sandhu, S., Devillé, W., Dia, H., Dias, S., Gddini, A., Ioannidis, E., Jensen, N.J., Kluge, U., Mertaniemi, R., Puigpinós I Riera, R., Sárváry, A., Straßmayr, C., Stankunas, M., Soares, J, J, F., Welbel, M., and Priebe, S. for the EUGATE study group. (2012). Health care for irregular migrants: pragmatism across Europe. A qualitative study, *BMC Research notes*, 5:99.

Davey Smith, G. (2000). Learning to live with complexity: ethnicity, socioeconomic position, and health in Britain and the United States. *American Journal of Public Health* 90,11:1694-1698

Derose, K. P., Escarce, J. J., and Lurie, N. (2007). Immigrants and health care: sources of vulnerability, *Health Affairs*, 26: 5,1258-1268.

Diabetes UK. (2012). Diabetes in the UK 2012: Key Statistics on Diabetes. Available at: <http://www.diabetes.org.uk/diabetes-in-the-uk-2012>, (Accessed 01/09/15).

Diabetes.co.uk. (2017). Diabetes and ethnicity. Available at: <http://www.diabetes.co.uk/diabetes-and-ethnicity.html>, (Accessed 10/01/17).

Diaz, E., Kumar, B.N., Gimeno-Feliu, L-A., Calderón-Larrañaga, A., Poblador-Pou, B., and Prados-Torres, A. (2015). Multimorbidity among registered immigrants in Norway:

the role of reason for migration and length of stay, *Tropical Medicine and International Health*, 20:12, 1805-1814.

Dixon-Woods M, Kirk D, Agarwal S, Annandale E, Arthur T, Harvey J, Hsu R, Katbamma S, Olsen R, Smith L, Riley R and Sutton A (2005): Vulnerable groups and access to health care: a critical interpretive review. *Report for the National Co-ordinating Centre for NHS Service Delivery and Organisation R&D (NCCSDO)*.

Dixon-Woods M, Cavers D, Agarwal S, Annandale E, Arthur A, Harvey J, Hsu R, Katbamma S, Olsen R, Smith L, Riley R and Sutton A, J. (2006). Conducting a critical interpretive synthesis of the literature on access to healthcare by vulnerable groups, *BMC Medical Research Methodology*, 6:35-47.

Doctors of the World. (2017). News and blogs: The UK must not use the NHS as an anti-immigration tool. Available at: <https://www.doctorsoftheworld.org.uk/news/dotw-strongly-condemns-the-government-using-nhs-as-anti-immigration-tool>, (Accessed 21/02/17).

Doctors of the World and Just Fair. (2017). Right to Health for All. [Online]. Available at: http://docs.wixstatic.com/ugd/8a2436_dbec80f5004c42229e1e0a683c668f93.pdf, (Accessed 10/07/17).

Durieux-Paillard, S. (2011). Differences in language, religious beliefs and culture: the need for culturally responsive health services in Rechel, B., Mladovsky, P., Deville, W., Rijks, B., Petrova-Benedict, R., and McKee, M. (eds.), *Migration and Health in the European Union*. Berkshire: McGraw Hill.

Editorial. (2017). Should we officially recognise obesity as a disease? *The Lancet Diabetes and Endocrinology*, 5:483.

Elliott, E., Popay, K., and Williams, G. (2016). Knowledge of the everyday: confronting the causes of health inequalities in K. E Smith, S Hill and C Bambra (eds.) *Health inequalities: critical perspectives*. Oxford: Oxford University Press.

European Council on Fundamental Rights. (2017). Health entitlements of migrants in an irregular situation in the EU-28. Available at: <http://fra.europa.eu/en/theme/asylum-migration-borders/healthcare-entitlements>, (Accessed 11/09/17)

European Union. (2017). Migration: Towards A European Agenda on Migration. Available at: https://ec.europa.eu/commission/priorities/migration_en, (Accessed 10/09/17).

Farmer, P. (2004). An anthropology of structural violence. *Current Anthropology*, 43:3, 305-325.

Farmer, P. (2005). *Pathologies of power: health, human rights and the new war on the poor*. London: University of California Press.

Farooqi, A., Nagra, D., Edgar, T., and Khunti, K. (2000). Attitudes to lifestyle risk factors for coronary heart disease amongst South Asians in Leicester: a focus group study, *Family Practice*, 17:4, 293-297.

Feldman, R. (2006). Primary health care for refugees and asylum seekers: a review of the literature and a framework for services. *Public Health*, 120:809-816.

Fleischman, Y., Willen, S., Davidovitch, N., and Mor, Z. (2015). Migration as a social determinant of health for irregular migrants: Israel as a case study, *Social Science and Medicine*, 146:89-97.

Flores, G. (2005). The impact of medical interpreter services on the quality of health care: a systematic review, *Medical Care Research and Review*, 62:3, 255-299.

Friedli, K. (2013). 'What we've tried hasn't worked': the politics of asset-based public health, *Critical Public Health*, 23:2, 131-145.

Gagnon, A.J., Carnevale, F.C., Mehta, P., Rousseau, H., and Stewart, D.E. (2013). Developing population interventions with migrant women for maternal-child health: a focused ethnography, *BMC Public Health*, 13:471-485.

Galleta, A. (2013). *Mastering the semi-structured interview and beyond: from research design to analysis and publication*. New York: New York University Press.

Garcia, C.M., Eisenberg, M.E., Frerich, E.A., Lechner, K.E., and Lust, K. (2012). Conducting go-along interviews to understand context and promote health, *Qualitative Health Research*, 22:10, 1395-1403.

GBD 2015 Risk Factors Collaborators. (2016). Global, regional, and national comparative risk assessment of 79 behavioural, environmental and occupational, and metabolic risks or clusters of risks, 1990-2015: a systematic analysis for the Global Burden of Disease Study 2015, *Lancet*, 388:1659-1724.

GBD Mortality and Causes of Death Collaborators. (2016). Global, regional, and national life expectancy, all-cause mortality, and cause-specific mortality for 249 causes of death, 1980-2015: a systematic analysis for the Global Burden of Disease Study, *Lancet*, 388:1459-1544.

Gee, G.C., and Ford, C.L. (2011). Structural racism and health inequities: old issues, new directions, *Du Bois Review* 8:1, 115-132.

Gentles, S. J., Charles, C., Ploeg, J., and McKibbin, K. (2015). Sampling in qualitative research: insights from an overview of the methods literature, *The Qualitative Report*, 20:11, 1772-1789.

Gerrish, K., Naisby, A., and Ismail, M. (2013). Experiences of the diagnosis and management of tuberculosis: a focused ethnography of Somali patients and healthcare professionals in the UK, *Journal of Advanced Nursing*, 69:10, 2285-2294.

Gill, P. S., Kai, J., Bhopal, R. S., and Wild, S. (2007). Health care needs assessment: black and minority ethnic groups. In: Raftery, J., Stevens, A., Mant, J. (eds). *Health Care Needs Assessment. The Epidemiologically Based Needs Assessment Reviews 3rd Series*. Abingdon: Radcliffe.

Gill, P. S., Beavan, J., Calvert, M., and Freemantle, N. (2011). The unmet need for interpreting provision in UK primary care, *PLoS ONE*, 6:6, e20837.

Glasgow Centre for Population Health. (2008). Perceived barriers in accessing healthcare services: asylum seekers and refugee (ASRs) and service providers' perspectives. Briefing Paper. [Online]. Available at: http://www.gcph.co.uk/assets/0000/0389/GCPH_briefing_paper_FS_134.pdf, (Accessed 06/06/17).

Glasgow University. (2018). GPs at the Deep End. Available at: <https://www.gla.ac.uk/researchinstitutes/healthwellbeing/research/generalpractice/deepend/about/>, (Accessed 26/02/18).

Go Well. (2017). About. Available at: www.gowellonline.com/about, (Accessed 12/09/17).

Gov.uk. (2014). NHS entitlements: migrant health guide. Available at: <https://www.gov.uk/guidance/nhs-entitlements-migrant-health-guide>, (Accessed 12/06/17).

Gov.uk (2017). Asylum support. Available at: <https://www.gov.uk/asylum-support/what-youll-get>, (Accessed 18/07/17).

Graetz, V., Rechel, B., Groot, W., Norredam, M., and Pavlova, M. (2017). Utilization of health care services by migrants in Europe – a systematic literature review, *British Medical Bulletin*, 121:5-18.

Greenhalgh, T., Rob, N., and Scambler, S. (2006). Communicative and strategic action in interpreted consultations in primary health care: A Habermasian Perspective, *Social Science and Medicine*, 63: 1170-1187.

Greenslade, R. (2005). Seeking scapegoats: the coverage of asylum in the UK press. London: IPPR.

Gruer, L., Cézard, G., Clark, E., Douglas, A., Steiner, M., Millard, A., Buchanan, D., Katikireddi, S.V., Sheikh, A, and Bhopal, R. (2016). Life expectancy of different ethnic groups using death records linked to population census data for 4.62 million people in Scotland, *Journal of Epidemiology and Community Health*, 70:1251-1254.

Guillemin, M., and Gillam. L. Ethics, reflexivity, and “ethically important moments” in research, *Qualitative Inquiry*, 10:2, 261-280.

Gulliford, M., Figueroa-Munoz, J., Morgan, M., Hughes, D., Gibson, B., Beech, R., and Hudson, M. (2002). What does ‘access to healthcare’ mean? *Journal of Health Services Research and Policy*, 7:3, 186-188.

Hanenfeld, J., Vearey, J., and Lunt, N. on behalf of the Researchers on Migration, Mobility and Health Group. (2017). A global research agenda on migration, mobility, and health, *The Lancet*, 389:2359.

Harris, M. F. (2012) Access to preventive care by immigrant populations. *BMC Medicine*, 10:55-56

Hart, L., and Horton, R. (2017). Syndemics: committing to a healthier future, *The Lancet*, 389, 888-889.

Harvey, N. (2017). Pregnant women frightened away from healthcare in the UK, *Doctors of the World Blog*. Available at: <https://www.doctorsoftheworld.org.uk/news/pregnant-women-should-never-be-frightened-away-from-antenatal-care>, (Accessed 26/09/17).

Hawkins, O. (2017). *Asylum Statistics Briefing Paper*. London: House of Commons Library.

Head, E. (2009). The ethics and implications of paying participants in qualitative research, *International Journal of Social Research Methodology*, 12,4:335-344.

Henderson, S., Kendall, E., and See, L. (2011). The effectiveness of culturally appropriate interventions to manage or prevent chronic disease in culturally and linguistically diverse communities: a systematic literature review, *Health and Social Care in the Community*, 19:3, 225-249.

Hendriks, A. M., Gubbels, J. S., Jansen, M. W. J, & Kremers S. P. J. (2012). Health beliefs regarding dietary behaviour and physical activity of Surinamese immigrants of Indian descent in the Netherlands: a qualitative study, *International Scholarly Research Network, Volume 2012*: 1-8.

Higginbottom, G. M. A., Pillay, J.J.and Boadu, N.Y. (2013). Guidance on performing focused ethnographies with an emphasis on healthcare research, *The Qualitative Report*, 18:17, 1-16.

Hill, S. (2016). Axes of Health Inequalities and intersectionality in K. E Smith, K.E., Hill, S., and Bambra, C. (eds.) *Health inequalities: critical perspectives*. Oxford: Oxford University Press.

- Hodgetts, D and Chamberlain, K. (2000). The social negotiation of people's views on the causes of illness, *Journal of Health Psychology*, 5:3, 325-336.
- Holmes, S. (2006). An ethnographic study of the social context of migrant health in the United States, *PLoS Medicine*, 3:10, 1776-1793.
- Holmes, S. (2012). The clinical gaze in the practice of migrant health: Mexican migrants in the United States, *Social Science and Medicine*, 74:873-881.
- Home Office. (2017a). National Statistics: Asylum. Available at: <https://www.gov.uk/government/publications/immigration-statistics-october-to-december-2016/asylum#support-provided-to-asylum-seekers>, (Accessed 14/06/17).
- Home Office. (2017b). Allocation of accommodation policy: Version 5.0. London: Home Office. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/597382/Allocation-Of-Accommodation-v5_0.pdf, (Accessed 23/09/17).
- Hunt, L, M., and deVoogd, K, B. (2005). Clinical myths of the cultural “other”: Implications for Latino patient care, *Academic Medicine*, 80: 10, 918-924.
- Ingleby, D. (2011). Good practice in health service provision for migrants. In Rechel, B., Mladovsky, P., Deville, W., Rijks, B., Petrova-Benedict, R., McKee, M. (eds.), *Migration and Health in the European Union*. Berkshire: McGraw Hill.
- Ingleby, D. (2012a). Introduction. In Ingleby, D., Krasnik, A., Lorant, V., Razum, O. (Eds.), *Cost Series on Health and Diversity Volume 1: Health Inequalities and Risk Factors among Migrants and Ethnic Minorities*. (pp.9-25). Antwerp-Apeldoorn: Garant Publishers.
- Ingleby, D. (2012b). Ethnicity, migration, and the social determinants of health agenda, *Psychosocial Intervention*, 21:3, 331-341.
- Jayaweera, J. (2010). Health and access to health care of migrants in the UK, *Better Health Briefing*, 19:1-6.

- Jayaweera, H. (2014). Social determinants of migrants' health *in* Anderson, B. and Keith, M. (eds.) *Migration: a COMPAS anthology*. Migration Observatory: Oxford.
- Jenkins, R. (1996). "Us" and "them": ethnicity, racism and ideology in Barot, R. (ed.) *The Racism problematic: contemporary debates on race and ethnicity*. Lewiston: The Edwin Mellen Press.
- Jones, D.J., and Gill, P.S. (1998). Refugees and primary care: tackling the inequalities, *BMJ*, 317:1444-6
- Joshi, C., Russell, G., Cheng, I., Kay, M., Pottie, K., Alston, M., Smith, M., Chan, B., Vasi, S., Lo, W., Wahidi, S S., and Harris, M F. (2013). A narrative synthesis of the impact of primary health care delivery models for refugees in resettlement countries on access, quality and coordination, *International Journal for Health Equity*, 12:88-100.
- Kai, J., Beavan, J., Fauli, C., Dodson, L., Gill, P., and Beighton, A. (2007). Professional uncertainty and disempowerment responding to ethnic diversity in health care: a qualitative study, *PLoS Medicine*, 4:11, 1766-1775.
- Kallayova, D., and Majdan, M. (2012). Involvement of migrants in health promotion interventions: results of the EU project 'Healthy Inclusion'. In Ingleby, D., Krasnik, A., Lorant, V. and Razum, O. (Eds.), *Cost Series on Health and Diversity Volume 1: Health Inequalities and Risk Factors among Migrants and Ethnic Minorities*. Antwerp-Apeldoorn: Garant Publishers.
- Kampf, A., and Goksu, A. (2013). Perceptions of Risk and preventive strategies with respect to cardiovascular diseases in people of Turkish migrant background in Germany, *Critical Public Health*, 24:1, 22-34.
- Kapilashrami, A., Hill, S., and Meer, N. (2015). What can health inequalities researchers learn from an intersectionality perspective? Understanding social dynamics with an inter-categorical approach, *Social Theory and Health*, 13:3/4, 288-307.
- Karliner, L.S., Jacobs, E.A., Chen, A. H., and Mutha, S. (2007). Do professional interpreters improve clinical care for patients with limited English proficiency? A systematic review of the literature, *Health Services Research*, 42:2, 727-754.

Karlsen S and Nazroo J Y. (2002). Agency and structure: the impact of ethnic identity and racism on the health of ethnic minority people. *Sociology of Health and illness*. 24:1, 1-20.

Karlsen, S., and Nazroo, J.Y. (2006). 'Defining and measuring ethnicity and race: theoretical and conceptual issues for health and social care research' in Nazroo, J.Y. (ed.) *Health and social research in multi-ethnic societies*. Oxford: Routledge.

Kearns, A., Whitley, E., Egan, M., Tabbner, C., and Tannahil, C. (2017). Healthy migrants in an unhealthy city? The effects of time on the health of migrants living in deprived areas of Glasgow, *International Journal of Migration and Integration*, 18:3, 675-698.

Keith, L., and van Ginneken, E. (2015). Restricting access to the NHS for undocumented migrants is bad policy at high cost, *BMJ*, 350:h3056

Kelleher, D. 1996. A defence of the use of the terms 'ethnicity' and 'culture' in Kelleher, D., and Hillier, S. (eds.) *Researching cultural differences in health*. London: Routledge.

Ketso. (2014). Ketso: The Hands on Kit for Creative Engagement. Available at: www.Ketso.co.uk, (Accessed 23/03/2014).

Khanassov, V., Pluye, P., Descoteaux, S., Haggerty, J.L., Russel, G., Gunn, J., and Levesque J.F. (20216). Improving access to community based primary health care for vulnerable populations: a scoping review, *International Journal for Equity in Health*, 15:168

Khunti, K., and Semani, N.J. (2004). Coronary heart disease in people of South-Asian origin, *The Lancet*, 364: 9451, 11-17.

Kings Fund. Primary Prevention. Available at: <https://www.kingsfund.org.uk/projects/gp-commissioning/ten-priorities-for-commissioners/primary-prevention>, (Accessed 18/07/17).

Kings Fund. Secondary Prevention. Available at: <https://www.kingsfund.org.uk/projects/gp-commissioning/ten-priorities-for-commissioners/secondary-prevention>, (Accessed 18/07/17).

Kings Fund. What is social prescribing? Available at: <https://www.kingsfund.org.uk/publications/social-prescribing>, (Accessed 24/09/17).

Klassen, C. A., Smith, K.C., Shariff-Marco, S., and Juon H-S. (2008). A healthy mistrust: how worldview relates to attitudes about breast cancer screening in a cross sectional survey of low-income women, *International Journal for Equity in Health*, 7:5.

Kleinman, A., Eisenberg, L., and Good, B. (1978). Culture, illness and care: clinical lessons from anthropological and cross-cultural research, *Annals of Internal Medicine*, 88:2, 251-258.

Kleinman, A. (1988). *The illness narratives: suffering, healing and the human condition*. USA: Basic Books.

Kleinman, A., and Benson, P. (2006). Anthropology in the clinic: the problem of cultural competency and how to fix it, *PLoS Medicine*, 3:10, 1673-1676.

Kline, R. (2014). The “snowy white peaks” of the NHS: a survey of discrimination in governance and leadership and the potential impact on patient care in London and England. London: Middlesex University.

Knoblauch, H. (2005). Focused Ethnography. *Forum: Qualitative Social Research*, 6:3. [Online]. Available at: <http://www.qualitativeresearch.net/index.php/fqs/article/view/20/43>, (Accessed 02/07/17).

Koehn, S. (2009). Negotiating candidacy: ethnic minority seniors’ access to care, *Ageing and Society*, 29:585-608.

Kovandzic, M., Chew-Graham, C., Reeve, J., Edwards, S., Peters, S., Edge, D., Aseem, S., Gask, L. and Dowrick, C. (2011). Access to primary mental health care for hard-to-reach groups: from “silent suffering” to “making it work”, *Social Science and Medicine*, 72:763-772.

Kovandzic, M., Funnell, E., Hammond, J., Ahmed, A., Edwards, S., Clarke, P., Hibbert, D., Bristow, K., and Dowrick, C. (2012). The space of access to primary mental health care: a qualitative case study, *Health and Place*, 18:536-551.

Krieger, N. (1990). Racial and gender discrimination: risk factors for high blood pressure, *Social Science and Medicine*, 30: 23, 1273-1281.

Krieger, N. (1999). Embodying inequality: a review of concepts, measure and methods for studying health consequences of discrimination, *International Journal of Health Services*, 29:3, 295-352.

Krieger, N. (2008). Proximal, distal and the politics of causation: what's level got to do with it? *American Journal of Public Health*, 2: 221-230.

Kunst, A.E., Stronks, K., and Agyemang, C. (2011). Non-communicable diseases in Rechel, B., Mladovsky, P., Deville, W., Rijks, B., Petrova-Benedict, R. and McKee, M. (eds.) *Migration and Health in the European Union*. Berkshire: McGraw Hill.

Kushner, T. (2003). Meaning nothing but good: ethics, history and asylum-seeker phobia in Britain, *Patterns of Prejudice*, 37: 3, 257-276.

Lambert, H and Sevak, L. (1996). Is 'cultural difference' a useful concept? in Kelleher, D and Hillier, S. (eds.) *Researching cultural differences in health*. London: Routledge.

Lambert, H., and McKeivitt, C. (2002). Anthropology in health research: from qualitative methods to multidisciplinary, *BMJ*, 3235:210-213.

Larchanché, S. (2012). Intangible obstacles: health implications of stigmatization, structural violence, violence, and fear among undocumented immigrants in France, *Social Science and Medicine*, 74:858-863.

Lay, B., Lauber, C., Nordt, C., and Rossler, W. (2006). Patterns of inpatient care for immigrants in Switzerland: a case control study, *Soc Psychiatr Epidemiol*, 41:199-207.

Liburd, L.C., Jack Jr, L. J., Williams, S., and Tucker, P. (2005). Intervening on the social determinants of cardiovascular disease and diabetes, *American Journal of Preventive Medicine*, 29:18-24.

Lindenmeyer, A., Redwood, S., Griffith, L., Ahmed, S., and Phillimore, J. (2016a). Recent migrants' perspectives on antibiotic use and prescribing in primary care: a qualitative study. *British Journal of General Practice Online First*, 2016.

Lindenmeyer, A., Redwood, S., Griffith, L., Teladia, Z., and Phillimore, J. (2016b). Experiences of primary care professionals providing healthcare to recently arrived migrants: a qualitative study, *BMJ Open*, 6:e012561.

Links Worker Programme. Available at: <http://links.alliance-scotland.org.uk/>, (Accessed 27/09/17).

Liu, J. J., Davidson, E., Bhopal, R., White, M., Johnson, M., Netto, G., and Sheikh, A. (2016). Adapting health promotion interventions for ethnic minority groups: a qualitative study, *Health Promotion International*, 31:2, 325-334.

Lorenc, T., Petticrew, M., Welch, V., and Tugwell, P. (2013). What types of interventions generate inequalities? Evidence from systematic reviews, *Journal of Epidemiology and Community Health*, 67:190-193.

Lukachko, A., Hatzenbuehler, M., and Keyes, K. M. (2014). Structural racism and myocardial infarction in the United States, *Social Science and Medicine*, 103:42-50.

Lynam, M.J., and Cowley, S. (2007). Understanding marginalization as a social determinant of health, *Critical Public Health*, 17:2, 137-149.

Lyons, K., and Duncan, P. (2017). 'It's a shambles': data shows most asylum seekers put in poorest parts of Britain. *Guardian Newspaper*, 9 April [Online]. Available at: <https://www.theguardian.com/world/2017/apr/09/its-a-shambles-data-shows-most-asylum-seekers-put-in-poorest-parts-of-britain>, (Accessed 14/06/17).

Lupton, D. (2013). *Risk*. London: Routledge.

Macdonald, S., Blane, D., Browne, S., Conway, E., Macleod, U., May, C., and Mair, F. (2016). Illness identity as an important component of candidacy: contrasting experiences of help-seeking and access to care in cancer and heart disease, *Social Science and Medicine*, 168:101-110.

MacFarlane, A., Dzebisova, Z., Karapish, D., Kovacevic, B., Ogbemor, F., and Okonkwo, E. (2009). Arranging and negotiating the use of informal interpreters in general practice consultations: experiences of refugees and asylum seekers in the west of Ireland, *Social Science and Medicine*, 69:210-214.

Mackenzie, M., Turner, F., Platt, S., Reid, M., Wang, Y., Clark, J., Sridharan, S. and O'Donnell, C. A. (2011). What is the problem that outreach work seeks to address and how might it be tackled? Seeking theory in a primary health prevention programme, *BMC Health Services Research*, 11:350-362.

Mackenzie, M., Conway, E., Hastings, A., Munro, M. and O'Donnell, C. (2013). Is 'candidacy' a useful concept for understanding journeys through public services? A critical interpretive literature synthesis, *Social Policy and Administration*, 47:806-825.

Mackenzie, M., Conway, E., Hastings, A. Munro, M., and O'Donnell, C.A. (2015) Intersections and multiple "candidacies": exploring connections between two theoretical perspectives on domestic abuse and their implication for practicing policy, *Social Policy and Society*, 14:43-62.

Madden, H., Harris, J., Blickem, C., Harrison, R., and Timpson, H. (2017). "Always paracetamol, they give them paracetamol for everything": a qualitative study examining Eastern European migrants' experiences of the UK health service, *BMC Health Services Research*, 17:604.

Malmusi, D., Borrell, C., and Benach, J. (2010). Migration related health inequalities: showing the complex interactions between gender, social class and place of origin, *Social Science and Medicine*, 71:1610-1619.

Marmot, M., Stansfeld, S., Patel, C., North, F., Head, J., White, I., Brunner, E., Feeney, A., Davey-Smith, G. (1991). Health inequalities among British civil servants: the Whitehall II study, *The Lancet*, 337:8574, 1387-1393.

Marmot, M. (2005). Social Determinants of Health Inequalities. *Lancet*, 365:1099-1104.

Marmot, M. (2010). *Fair society, healthy lives: The Marmot Review: strategic review of health inequalities in England post-2010*. London: University College London.

Marrow, H. B. (2012). Deserving to a point: unauthorized immigrants in San Francisco's universal access to healthcare model, *Social Science and Medicine*, 74:846-854.

Martinez, O., Wu, E., Sandfort, T., Dodge, B., Carballo-Diequez, A., Pinto, R., Rhodes, S., Moya, E., Chavez-Baray, S., (2015), Evaluating the impact of immigration policies on

health status among undocumented immigrants: a systematic review, *J Immigrant Minority Health*, 17:947-970.

Matthews, P., Netto, G., and Besemer, K. (2012). 'Hard-to-Reach' or 'Easy-to-ignore'? A rapid review of place-based policies and equality. Scotland: Equality and Human Rights Commission.

McCartney, M. (2011). Doctors should stop supporting unethical screening, *BMJ*, 343:4592.

McCullum, D., Nowak, B., and Tindal, S. (2014). Public attitudes towards migration in Scotland: exceptionality and possible policy implications, *Scottish Affairs*, 23:1, 79-102.

McKeown, R.E. (2009). The epidemiologic transition: changing patterns of mortality and population dynamics, *American Journal of Lifestyle Medicine*, 1:3 (1 suppl): 19S-26S.

Migration Observatory. (2014). *Immigration and independence: Public opinion on immigration in Scotland in the context of the referendum debate*. [Online]. Available at: <http://www.migrationscotland.org.uk/migration-toolkit/building-good-relations/6-2-understanding-tensions>, (Accessed 23/05/17).

Mir, G., Salway, S., Kai, J., Karlsen, S., Bhopal, R., Ellison, G.T.H. and Sheikh, A. (2012). Principles for research on ethnicity and health: The Leeds consensus statement, *European Journal of Public Health*, 23: 3, 504-510.

Mladovsky, P. (2011). Migrant health policies in Europe. In B Rechel, P Mladovsky, W Deville, B Rijks, R Petrova-Benedict and M McKee (eds.), *Migration and Health in the European Union*. Berkshire: McGraw Hill.

Moberly, T. (2015). Doctors should refuse to check patients' immigration status, says BMA. *BMJ*, 250:h3468.

Moberly, T. (2017). Should we allow overseas visitors free access to NHS services? *BMJ*, 358:j3665.

Modood, T. (1996). If races do not exist, then what does? Racial categorisation and ethnic realities in R Barot (ed.) *The Racism problematic: contemporary debates on race and ethnicity*. Lewiston: The Edwin Mellen Press.

Muecke, M. (1994). On the evaluation of ethnographies, in Morse, J. (ed). *Critical issues in qualitative research methods*. UK: Sage Publications.

Mulvey, G. (2009). *Refugee and Asylum Seeker research in Scotland: a literature review*. Glasgow: Scottish Refugee Council.

Mulvey, G. (2010). When policy creates politics: the problematizing of immigration and the consequences for refugee integration in the UK, *Journal of Refugee Studies*, 23:4, 437-462.

Mulvey, G. (2013). *In search of normality: refugee integration in Scotland*. Glasgow: Scottish Refugee Council.

Mulvey, G. (2015). Refugee integration policy: The effects of UK policy making on refugees in Scotland, *Journal of Social Policy*, 44:2, 357-375.

Nazroo, J. (1998). Genetic, cultural or socio-economic vulnerability? Explaining ethnic inequalities in health, *Sociology of health and illness*, 20:5, 710-730.

Nazroo, J. (2003). The structuring of ethnic inequalities in health: economic position, racial discrimination, and racism, *American Journal of Public Health*. 93:2, 277-284.

Nazroo, J. (2006). Demography of multicultural Britain in J Nazroo (ed). *Health and social research in multi-ethnic societies*. London: Routledge.

Netto, G., McCloughlan, L., Bhatnagar, A. (2007). Effective heart disease prevention: lessons from a qualitative study of user perspectives in Bangladeshi, Indian and Pakistani communities, *Public Health*, 121: 177-186.

Netto G, Bhopal R, Lederle N, Khaton J and Jackson A (2010) How can health promotion interventions be adapted for minority ethnic communities? Five principles for guiding the development of behavioural interventions, *Health Promotion International*, 25:2, 248-257.

Netto, G., Sosenko, F., and Bramley, G. (2011). *Poverty and ethnicity in Scotland: review of the literature and data sets*. Joseph Rowntree Foundation.

Netto, G. (2012). Health promotion interventions for migrant groups: the need for a strategic approach and key principles. In Ingleby, D., Krasnik, A., Lorant, V., and Razum, O. (eds.), *Cost Series on Health and Diversity Volume 1: Health Inequalities and Risk Factors among Migrants and Ethnic Minorities*. Antwerp-Apeldoorn: Garant Publishers.

NHS Greater Glasgow and Clyde. (2017). Asylum Health Bridging Team (AHBT). Available at: <http://www.nhsggc.org.uk/your-health/health-services/homeless-health-and-resource-services/homelessness-health-services/asylum-health-bridging-team-ahbt/>, (Accessed 23/05/17).

NHS Greater Glasgow and Clyde. Equalities in Health. NHS GGC Interpreting Service. Available at: http://www.equalitiesinhealth.org/public_html/staff_working_with_interpreters.html, (Accessed 003/02/17).

NHS Health Scotland. (2015). Evaluation of Keepwell. Available at: <http://www.healthscotland.com/scotlands-health/evaluation/programme/evaluation-%20KeepWell.aspx>, (Accessed 22/02/17).

Nicolaou, M., Vlaar, E., Van Valkengoed, I., Middelkoop, B., Stronks, K., and Nierkens, V. (2014). Development of a diabetes prevention program for Surinamese South Asians in the Netherlands, *Health Promotion International*, 29:4, 680-691.

Normansell, R., Drennan, V. M., and Oakeshott, P. (2015). Exploring access and attitudes to regular sexually transmitted infection screening: the views of young, multi-ethnic, inner city, female students, *Health Expectations*, 19:2, 322-330.

Norredam, A., Nielsen, S.S., and Krasnik, A. (2010). Migrants' utilization of somatic healthcare services in Europe – a systematic review, *European Journal of Public Health*, 20:5, 555-563.

Norredam, M. and Krasnik, A. (2011). Migrants' access to health services. In Rechel, B., Mladovsky, P., Deville, W., Rijks, B., Petrova-Benedict, R., and McKee, M. (eds.), *Migration and Health in the European Union*. Berkshire: McGraw Hill.

- Oakley, A. (1981). Interviewing women: a contradiction in terms *in* Roberts, H. (ed.) *Doing Feminist Research*. London:Routledge.
- Obrist, B., Van Eeuwijk, P., and Weiss G.M. (2010). Health anthropology and urban health research, *Anthropology and Medicine*, 10: 3, 267-274.
- O'Donnell, C A., Higgins, M., Chauhan, R., and Mullen, K. (2007). "They think we're OK and we know we're not". A qualitative study of asylum seekers' access, knowledge and views to health care in the UK, *BMC Health Services Research*, 7: 75-84.
- O'Donnell, C A., Higgins, M., Chauhan, R., and Mullen, K. (2008). Asylum seekers' expectations of and trust in general practice: a qualitative study, *British Journal of General Practice*, e1-e11.
- O'Donnell, C.A., Burns, N., Mair, F.S., Dowrick, C., Clissmann, C., van den Muijsenbergh, M., van Weel-Baumgarten, E., Lionis, C., Papadakaki, M., Saridaki, A., de Brun, T., MacFarlane, A. (2016). Reducing the health care burden for marginalised migrants: the potential role for primary care in Europe, *Health Policy*, 120:495-508.
- Ormston, R., Spencer, L., Barnard, M., and Snape, D. (2014). The foundations of qualitative research *in* Ritchie, J., Lewis, J., McNaughton Nicholls, C. and Ormston, R. (eds.) *Qualitative Research Practice*. London: Sage.
- Page-Reeves. J., Mishra. S.I., Niforatos. J., Regino. L., Gingerich., and Bulten, R. (2013a). An integrated approach to diabetes prevention: anthropology, public health, and community engagement, *The Qualitative Report*, 18: 98, 1-22.
- Page-Reeves, J., Niforatos, J., Mishra, S., Regino, L., Gingrich, A., and Bulten, R. (2013b). Health disparity and structural violence: how fear undermines health among immigrants at risk for diabetes, *J Health Dispar Res Pract*, 6:2, 30-47.
- Palinkas, L. A., Pickwell, S. M., Brandstein, K., Clark T. J., Hill, L. L., Moser, R. J., and Osman, A. (2003). The journey to wellness: stages of refugee health promotion and disease prevention, *Journal of Immigrant Health*, 5: 1, 19-28.

- Patel, M., Phillips-Caesar, E., and Boutin-Foster, C. (2012). Barriers to lifestyle behavioural change in migrant South Asian populations, *Journal of Immigrant Minority Health*, 14:774-785.
- Pechansky, R. and Thomas, J.W. 1981. The concept of access: definition and relationship to consumer satisfaction, *Medical Care*, XIX:2, 127-140.
- Penn, L., Dombrowski, S. U., Sniehotta, F., and White, M. (2014). Perspectives of UK Pakistani women on their behaviour change to prevent type 2 diabetes: qualitative study using the theory domain framework, *BMJ Open*, 4:1-10.
- Phelan, J.C., Link, B.G., Diez-Roux, A., Kawachi, I., Levin, B. (2004). “Fundamental causes” of social inequalities in mortality: a test of the theory, *Journal of Health and Social Behaviour* 45:265-285.
- Phillimore, J., Ergun, E., Goodson, L., and Hennessy, D., with BNCN Community Researchers. (2007). “*They do not understand the problem I have*”. Refugee well being and mental health, Joseph Rowntree Foundation.
- Philo, G., Briant, E., and Donald, P. (2013). *Bad news for refugees*. London: Pluto Press.
- Platform for International Cooperation on Undocumented Migrants. Who are undocumented migrants? Available at: <http://picum.org/en/our-work/who-are-undocumented-migrants/>, (Accessed 01/08/17).
- Plaza del Pino, F.J., Soriano, E., and Higginbottom, G.M.A. (2013). Sociocultural and linguistic boundaries influencing intercultural communication between nurses and Moroccan patients in Southern Spain: a focused ethnography, *BMC Nursing*, 12:14-22.
- Popay, J., Thomas, C., Williams, G., Bennett, S., Gatrell, A., and Bostock, L. (2003). A proper place to live: health inequalities, agency and the normative dimensions of space, *Social Science and Medicine*, 57:55-69.
- Popay, J. (2012). The knowledge needed to deliver social justice and health equity. *International Journal of Qualitative Methods*.

Priebe, S., Sandhu, S., Dias, S., Gaddini, A., Greacen, T., Ioannidis, E., Kluge, U., Krasnik, A., Lamkaddem, M., Lorant, V., Riera, R P., Sarvary, A., Soares, J. J. F., Stankunas, M., Straßmayr, C., Wahlbeck, K., Welbel, M., and Bojic, M. (2011). Good practice in health care for migrants: views and experiences of care professionals in 16 European countries, *BMC Public Health*, 11:187-199.

Putland, C., Baum, F.E., and Ziersch, A.M. (2011). From causes to solutions – insights from lay knowledge about health inequalities, *BMC Public Health*, 11:67, 1-11.

Quesada, J., Kain Hart, L., and Bourgeois, P. (2011). Structural vulnerability and health: Latino migrant labourers in the United States, *Medical Anthropology*, 30:4, 339-362.

Quinn, N. (2014). Participatory action research with asylum seekers and refugees experiencing stigma and discrimination: the experience from Scotland, *Disability & Society*, 29:1, 58-70.

Raphael, D., and Bryant, T. (2015). Power, intersectionality and the life-course: identifying the political and economic structures of welfare states that support or threaten health, *Social Theory and Health*, 13:3/4, 245-266.

Rapley, T. (2001). The art(fullness) of open-ended interviewing: some considerations on analysing interviews, *Qualitative Research*, 1:3, 303-323.

Rechel, B., Mladovsky, P., Deville, W., Rijks, B., Petrova-Benedict, R., and McKee, M. (2011a). Migration and health in the European Union: an introduction. In Rechel, B., Mladovsky, P., Deville, W., Rijks, B., Petrova-Benedict, R., and McKee, M. (Eds.), *Migration and Health in the European Union*. Berkshire: McGraw Hill.

Rechel, B., Mladovsky, P., and Deville, W. (2011b). Monitoring the health of migrants, in Rechel, B., Mladovsky, P., Deville, W., Rijks, B., Petrova-Benedict, R., and McKee, M. (Eds.), *Migration and Health in the European Union*. Berkshire: McGraw Hill.

Rechel, B., Mladovsky, P., and Devillé, W. (2012). Monitoring migrant health in Europe: a narrative review of data collection practices, *Health Policy*, 105:10-16.

Rechel, B., Mladovsky, P., Ingleby, D., Mackenbach, J.P., and McKee, M. (2013). Migration and health in an increasingly diverse Europe, *Lancet*, 381:1235-1245.

Red Road Flats: Past, Present and Future... Available at: www.redroadflats.org.uk
(Accessed 23/09/17).

Reeves, M., Gilles, de Wildt, Murshali, H., Williams, P., Gill, P., Kralj, L., and Rushby, M. (2006). Access to healthcare for people seeking asylum in the UK, *British Journal of General Practice*, 56: 525, 306-308.

Refugee Council. (2017). The truth about asylum. Available at:
https://www.refugeecouncil.org.uk/policy_research/the_truth_about_asylum/the_facts_about_asylum, (Accessed 18/07/17).

Reilly, K. (2012). *Ethnographic methods*. Oxon: Routledge.

Rhodes, T., Wagner, K., Strathdee, S.A., Shannon, K., Davidson, P., and Bourgeois, P. (2011). Structural violence and structural vulnerability within the risk environment: theoretical and methodological perspectives for a social epidemiology of HIV risk among injection drug users and sex worker in O'Campo, P. and Dunn, J. R. (eds.) *Rethinking social epidemiology: towards a science of change*, Springer Link [online]. Available at: https://link.springer.com/chapter/10.1007%2F978-94-007-2138-8_10.

Rogers, J., and Kelly, U. A. (2011). Feminist intersectionality: bringing social justice to health disparities research, *Nursing Ethics*, 18:3, 397-407.

Salway, S., Piercy, H., Chowbey, P., Brewins, L. and Dhoot, P. (2013). Improving capacity in ethnicity and health research: report of tailored programme for NHS Public Health practitioners, *Primary Health Care Research and Development*, 14:330-340.

Salway, S., Mir, G., Turner, D., Ellison, G.T.H., Carter, L., and Gerrish, K. (2016). Obstacles to "race equality" in the English National Health Service: insights from the healthcare commissioning arena.

Sandvik, H., Hunskaar, S., and Diaz, E. (2012). Immigrants' use of emergency primary health care in Norway: a registry-based observational study, *BMC Health Services Research*, 12:308.

Sargent, C., and Larchanché, S. (2009). The construction of “cultural difference” and its therapeutic significance in immigrant mental health services in France. *Culture Med Psychiatry*, 33:2-20.

Sargent, C., and Larchanché, S. (2011). Transnational migration and global health: the production and management of risk, illness and access to care, *Annual Review of Anthropology*, 40:354-61

Scientific Advisory Committee on Nutrition. (2016). Vitamin D and health. London: UK Government. [Online]. Available at: www.gov.uk/government/groups/scientific-advisory-committee-on-nutrition, (Accessed 24/08/17).

Scottish Government. (2013). New Scots: integrating refugees in Scotland’s communities. Edinburgh: APS Group Scotland.

Scottish Government. (2015). New Scots: Integrating refugees in Scotland’s communities 2014-2017 final report. Edinburgh: APS Group Scotland.

Scottish Government. (2017). Which ethnic groups have the poorest health? Edinburgh: APS Group Scotland.

Scottish Refugee Policy Forum. (2012). A fairer Scotland for asylum seekers and refugees in a time of austerity? Glasgow: Scottish Refugee Council.

Sheikh, M. and MacIntyre, C. R. (2009). The impact of intensive health promotion to a targeted refugee population on utilisation of a new refugee paediatric clinic at the children’s hospital at Westmead, *Ethnicity and Health*, 14:4, 393-405.

Simonnot, N., Rodriguez, A., Nuernberg, M., File, F., Aranda-Fernández, P. E., and Chauvin, P. (2016). *Access to healthcare for people facing multiple vulnerability in health in 31 cities in 12 countries. Report on social and medical data gathered in 2015 in 11 European countries and Turkey*. France: Médecins du Monde.

Simpson, L. (2014). *How has ethnic diversity changed in Scotland?* Manchester: Centre on Dynamics of Diversity.

- Singer, M. (1995). Beyond the ivory tower: critical praxis in medical anthropology, *Medical Anthropology Quarterly*, 9:1, 80-106.
- Smith, K.E., & Eltanani, M. K. (2014). What kinds of policies to reduce health inequalities in the UK do researchers support? *Journal of Public Health*, 37: 1, 6-17.
- Smith, K.E., Bambra, C., and Hill, C. (2016). Background and introduction: UK experiences of health inequalities in Smith, K.E., Hill, S. and Bambra, C. (eds.) *Health inequalities: critical perspectives*. Oxford: Oxford University Press.
- Smith, M. (2016). Africans in Scotland: heterogeneity and sensitivities to HIV. (Doctoral Dissertation). Retrieved from: University of Glasgow thesis repository (theses.gla.ac.uk)
- Society for Academic Primary Care. (2017). About Us. Available at: <https://sapc.ac.uk/about>, (Accessed 27/06/17).
- Stagg, H., Jones, J., Bickler, G., and Abubakar, I. (2012). Poor uptake of primary healthcare registration among recent entrants to the UK: a retrospective cohort study, *BMJ Open*, 2:e001453.
- Stewart, E. (2005). Exploring the vulnerability of asylum seekers in the UK, *Population, Space and Place*, 11:499-512.
- Stewart, E. and Mulvey, G. (2014). Seeking safety beyond refuge: the impact of immigration and citizenship policy upon refugees in the UK, *Journal of Ethnic and Migration Studies*, 40:7, 1023-1039.
- Strang, A B and Quinn N. (2014). *Integration or isolation?: mapping social connections and well-being amongst refugees in Glasgow*. Glasgow: NHS Greater Glasgow and Clyde.
- Strang, A. (2015). Refugee peer education for health and wellbeing: evaluation report. Glasgow: Scottish Refugee Council.
- Strang, A., Bailiot, H., and Mignard, E. (2016). *Rights, resilience and refugee integration in Scotland: New Scots & the holistic integration service*. Glasgow: Scottish Refugee Council.

- Taylor, K.D., Adedokun, A., Awobusuyi, O., Adeniran, P., Onyia, E., and Ogedegbe, G. (2012). Explanatory models of hypertension among Nigerian patients at a university teaching hospital, *Ethnicity and Health*, 17:6, 615-629.
- Taylor, B., Rush, K.L., and Robinson, C.A. (2015). Nurses' experiences of caring for the older adult in the emergency department: a focused ethnography, *International Emergency Nursing*, 23:2, 185-189.
- Thurston, W E., and Vissandjee, B. (2005). An ecological model for understanding culture as a determinant of women's health. *Critical Public Health*, 15:3, 229-242.
- Ton, T, G, N., Steinman, L., Yip, M-P., Ly, K, A., Sin, M-K., Fitzpatrick, A, L., and Tu, S, P. (2011). Knowledge of cardiovascular health among Chinese, Korean and Vietnamese immigrants to the US, *Journal of Immigrant and Minority Health*, 13:127-139.
- Tylor, I. (2013). *Revolting subjects: Social abjection and resistance in neoliberal Britain*. London: Zed Books.
- Uiters, E., Devillé, W., Foets, M., Spreeuwenberg, P., and Groenewegen, P.P. (2009). Differences between immigrant and non-immigrant groups in the use of primary medical care: a systematic review, *BMC Health Services Research*, 9:76.
- UK Gov. (2017). Asylum support. Available at: <https://www.gov.uk/asylum-support/what-youll-get>, (Accessed 30/03/17).
- UNHCR. (2015). Global Trends Forced Displacement in 2015. Geneva: UNHCR. Available at: <http://www.unhcr.org/global-trends-2015.html>, (Accessed 14/06/17).
- UNHCR Office of the High Commissioner. (2017). International Covenant on Economic, Social and Cultural Rights 1966. Available at: <http://www.ohchr.org/EN/ProfessionalInterest/Pages/CESCR.aspx>, (Accessed 27/03/2017)
- Universities Scotland. (2016). Guidance on providing refugees and asylum seekers with higher education. Available at: <http://www.universities-scotland.ac.uk/wp-content/uploads/2016/11/Guidance-on-Providing-Asylum-Seekers-and-Refugees-with-Access-to-Higher-Education-Nov-2016.pdf> (Accessed 27/02/17).

Vargas-Silva, C. (2013). *Briefing: Migrants in Scotland; An Overview*, Oxford: Migration Observatory.

Viruell-Fuentes, E A., Miranda, P Y., and Abdulrahim, S. (2012). More than culture: structural racism, intersectionality theory and immigrant health, *Social Science and Medicine*, 75:2099-2106.

Wall, S. (2015). Focused ethnography: a methodological adaptation for social research in emerging contexts, *Forum: Qualitative Social Research*, 16:1, 1-15.

Warfa, N., Bhui, K., Craig, T., Curtis, S., Mohamud, S., Stansfeld, S., McCrone, P, and Thornicroft, G (2006) Post-migration geographical mobility, mental health and health service utilisation among Somali refugees in the UK: a qualitative study, *Health and Place*, 12:503-515.

Webster, S., Lewis, J., and Brown, A. (2014). The foundations of qualitative research in Ritchie, J., Lewis, J., and McNaughton Nicholls, C (eds.) *Qualitative Research Practice*. London: Sage.

Wei Yeoh, S. & Furler, J. (2011). Perceptions of health and diabetes in a Melbourne South Sudanese community, *Journal of Immigrant and minority health*, 13:5, :914-918.

Woodward, A., Howard, N., and Wolffers, I. (2014). Health and access to care for undocumented migrants living in Europe: a scoping review, *Health Policy and Planning*, 29:7, 818-830.

World Health Organization. (1978). Declaration of Alma-Ata. Available at: http://www.who.int/publications/almaata_declaration_en.pdf, (Accessed 27/06/17).

World Health Organization. (2013). Fact Sheet No.317: Cardiovascular diseases (CVDs). Available at: <http://www.who.int/mediacentre/factsheets/fs317/en/>, (Accessed 01/09/14).

World Health Organization. (2014a). Global Status Report on non communicable diseases. Switzerland: WHO.

World Health Organization. (2014b). Health Impact Assessment. Available at: <http://www.who.int/hia/evidence/doh/en/>, (Accessed).

World Health Organization Media Centre. (2015). Health and human rights. Fact sheet no.323. Available at: <http://www.who.int/mediacentre/factsheets/fs323/en/>, (Accessed 28/03/17).

World Health Organization. Nutrition. The Global burden of chronic disease. Available at: http://www.who.int/nutrition/topics/2_background/en/, (accessed 25/01/17).

World Heart Federation. (2017). Risk Factors. Available at: <https://www.world-heart-federation.org/resources/risk-factors/>, (Accessed 22/08/17).

Wren, K. (2007). Supporting asylum seekers and refugees in Glasgow: the role of multi-agency networks, *Journal of Refugee Studies*, 20:3, 391-413.

Van Wieringen, J.C.M., Harmsen, J.A.M., and Bruijnzeels, M.A. (2002). Intercultural communication in general practice, *European Journal of Public Health*, 12:63-68.

Vertovec, S. (2007). Super-diversity and its implications, *Ethnic and Racial Studies*, 30:6, 1024-1054.

White, M., Adams, J., and Heywood, P. (2009). How and why do interventions that increase health overall widen inequalities within populations? in Babones, S.J. (ed.) *Social Inequality and Public Health*. Bristol: Policy Press.

Willen, S.S., Knipper, M., Abadia-Barrero, C.E., and Davidovitch, N. (2017). Syndemic vulnerability and the right to health, *The Lancet*, 389, 964-977.

Worthington, E. (2017). *New regulations on healthcare charging, and the impact on refugees, people seeking asylum, and other vulnerable groups*. Asylum Matters. Available at: <https://cityofsanctuary.org/wp-content/uploads/2017/08/Asylum-Matters-Healthcare-Regulations-Briefing-2017-2.pdf>, (Accessed 13/09/17)

Yeo, A., Legard, R., Keegan, J., and Ward, K. (2013). In depth interviews in Ritchie, J., Lewis, J., McNaughton Nicholls, C (eds.) *Qualitative Research Practice*. London: Sage.

Yeo, C. (2017). Home Office ends policy of automatic settlement for refugees after five years, *Free Movement Blog*. Available at: <https://www.freemovement.org.uk/home-office-ends-policy-automatic-settlement-refugees-five-years/>, (Accessed 24/09/17).

Yuval-Davis., Wemyss, G., and Cassidy, K. (2017). Everyday bordering, belonging and the reorientation of British immigration legislation, *Sociology*, 1-17.

Zhou, R., Majumdar, B., Vattikonda, N. (2016). Culture, but more than culture: an exploratory study of the HIV vulnerability of Indian immigrants in Canada, *Culture, Health and Sexuality*, 18:9, 1067-1080.

Ziebland S, and McPherson, M. (2006). Making sense of qualitative data analysis: an introduction with illustrations from DIPEX (personal experiences of health and illness), *Medical Education*, 40:405-414.

Zimmerman, C., Hossain, M., Kiss, L., Hoey, J., Weneden, K., Watts, C., Bhatti, S, Christie, G., and Baillot, H. (2009). *Asylum seeking women: violence and health. Results from a pilot study in Scotland and Belgium*. UK: LSHTM & SRC.

Zimmerman, C., Kiss, L., and Hossain, M. (2011). Migration and health: a framework for 21st century policy making, *PLoS Medicine*, 11:8, 1-7